



HEALTH MANAGEMENT ASSOCIATES

*Michigan's Workforce for Treating
Substance Use Disorders:
Is the Capacity Sufficient for Medicaid?*

*Report Provided to
The Michigan Department of Community Health
Bureau of Substance Abuse and Addiction Services*

MAY 2013

*Research and Consulting in the Fields of Health and Human Services Policy, Health Economics
and Finance, Program Evaluation, Data Analysis, and Health System Restructuring*

ATLANTA, GEORGIA • AUSTIN, TEXAS • BAY AREA, CALIFORNIA • BOSTON, MASSACHUSETTS • CHICAGO, ILLINOIS
DENVER, COLORADO • HARRISBURG, PENNSYLVANIA • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN • NEW YORK, NEW YORK
OLYMPIA, WASHINGTON • SACRAMENTO, CALIFORNIA • SOUTHERN CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Contents

Executive Summary.....	iii
Background	iii
Michigan’s IC&RC Certified Workforce	iv
Publicly Funded SUD Services	v
Impending Changes in the SUD Environment.....	v
Future Demand for Primary SUD Services	vi
Recruiting and Retaining IC&RC Credentialed Counselors	vi
Integration: A Possible Down Side	vii
Recommendations	vii
Introduction	1
Background on SUD Treatment Environment	3
Background	3
National and International Credentials and Standards	4
Michigan Credentialing Standards	5
Michigan’s IC&RC Credentialed Workforce	6
Demographics	6
Pay, Recruitment, and Retention of SUD Counselors	8
Michigan’s SUD Treatment Environment	11
The Service Continuum in Michigan	11
SUD Payors and Populations.....	11
Michigan Medicaid – Primary SUD	11
Michigan Medicaid – SUD Co-Occurring with Mental Illness	12
The Uninsured.....	12
The Public System’s Move to a Recovery-Oriented System of Care.....	13
Commercial Plans.....	13
Medicare	13
Michigan Department of Corrections	13
Court-Ordered Treatment.....	14
Self-Pay.....	14
Impending Changes in the Michigan SUD Environment	15

Public Delivery System Changes	15
Health Insurance Exchange Population	15
Medicaid Expansion	16
Federal Substance Abuse Block Grant	17
The Future Michigan Medicaid SUD Workforce	18
Will the Demand for Medicaid SUD Services Grow?	18
Is the Capacity of Today's IC&RC Credentialed SUD Counselors Sufficient?	19
Summary and Recommendations	21
Summary	21
Prior Recommendations	21
Recommendations for Michigan's Future SUD Workforce.....	22
Develop and Deploy BSAAS Leadership	22
Raise Reimbursement for SUD Services.....	23
Recruit New IC&RC Credentialed SUD Workers	24
Retain Credentialed SUD Counselors.....	24
Extend the Capacity of Credentialed SUD Counselors.....	24
Monitor Changes in the Field.....	25
Attachments.....	26
Attachment 1: Individuals and Organizations Interviewed	26
Attachment 2: County Definitions Used By HMA	27
Attachment 3: SUD Providers Contracted by Both Coordinating Agencies and Michigan Department of Corrections	28
Attachment 4: Summary of Recommendations Federal and State SUD Workforce Analysis 2006- 2012.....	33
Attachment 5: Treatment Provider Requirements by Payer and Patient Type.....	39
Attachment 6: Source of Referral to Outpatient Treatment: Michigan CAs FY 2011.....	40
Attachment 7: IC&RC Certification Requirements.....	41
Attachment 8: Trend: Coordinating Agency Funding by Source 2000 – 2010.....	42
Attachment 9: Statewide SUD Expenditures and Revenues: 2000-01 - 2010-11	43
Attachment 10: Funding Flow: Public Treatment System for SUD	45

Executive Summary

The Michigan Department of Community Health Bureau of Substance Abuse and Addiction Services (BSAAS) engaged Health Management Associates (HMA) to assess the ability of the current public safety net system to meet the substance abuse disorder (SUD) and addiction treatment needs of those impacted by coverage expansions authorized in the Affordable Care Act (ACA).

To complete this assessment, HMA conducted extensive interviews with policy makers, Regional Substance Abuse Coordinating Agencies (CA), credentialing bodies, counselors, Medicaid Prepaid Inpatient Health Plans (PIHP), consumers, trade associations, and staff of MDCH and the Michigan Department of Corrections (MDOC). We reviewed literature and data on national and state trends in the SUD treatment workforce, pay rates and SUD service provider certification in Michigan, and estimates of the prevalence of SUD expected in the expansion populations. We analyzed trends in funding and treatment numbers in the CAs over a decade and reviewed the cost-benefit literature on treating SUD. For consistency, our analysis and recommendations presume that Michigan will expand Medicaid under the provisions of the ACA, though a final decision has not yet been made.

HMA has distilled this complex analysis into the following conclusions.

1. There will likely be an increased demand for treatment of primary SUD as a result of the expansion of Medicaid eligibility and new access to subsidized insurance coverage through Michigan's Health Insurance Exchange.
2. There will likely be an increased demand for treatment of SUD co-occurring with mental illness and/or chronic medical conditions, and the presence of professionals trained in diagnosis and treatment of addictions will likely diminish in numbers and influence on the treatment teams in these settings.
3. Impending changes in the SUD service environment and on-going barriers to master's-level social workers seeking the International Certification and Reciprocity Consortium (IC&RC) credential and remaining in the credentialed workforce will reduce the number of IC&RC credentialed counselors who are master's-prepared. This will further reduce the pool of potential supervisors and of persons with SUD treatment expertise on integrated treatment teams.
4. Counselors credentialed in SUD treatment will be increasingly insufficient in Michigan's rural areas and possibly in the state's more populated areas as well.
5. MDCH and BSAAS need measures to monitor these changes and develop policy that addresses emerging concerns.

These scenarios threaten the quality and integrity of the treatment of SUDs in Medicaid, and we have structured recommendations to address them.

Background

Research has identified a positive correlation between alcohol and drug abuse and increased public expenditure for criminal justice, healthcare, and social welfare payments. The need for trained and

experienced addiction and prevention professionals is growing. According to the U.S. Department of Labor, the profession of substance abuse counseling is projected to grow 27 percent by 2020.

In 2006, a workgroup established by the Office of Drug Control Policy¹ recommended that Michigan's CAs adopt the IC&RC standards and reciprocity for the credentialing of addiction-related professionals. The recommendation supports the position that diagnosing and treating addictions is a specialized field requiring focused education, training, and credentialing. Today, the independent non-profit organization Michigan Certification Board for Addiction Professionals (MCBAP) operates the certification process.

The IC&RC supports a career ladder for prevention, treatment, and recovery professionals and makes this available to all levels of education (from those with no formal higher education to master's-level staff) and clinical practice. Contact hours for education are the same, but requirements for supervised work vary widely. Some professionals in the social work field and licensed SUD treatment agencies are suggesting that licensed social workers who provide counseling services, most of whom are master's prepared, have sufficient expertise to counsel persons with SUD without the additional lengthy and costly IC&RC certification. However, there are currently no requirements that Michigan's Schools of Social Work require or even offer any course work in addictions, and at least one program offers no such courses.

Michigan's IC&RC Certified Workforce

The IC&RC-certified SUD treatment workforce in Michigan has the following characteristics:

- Michigan's credentialed SUD service workforce mirrors the nation's in being heavily female and with limited racial and ethnic diversity.
- Turnover in the SUD service workforce is very high and is attributable to poor pay, high stress, and training/continuing education requirements that are costly and time consuming.
 - High workforce turnover is undesirable on many levels: it disrupts continuity of patient care, adds significant expense to the system in training costs, and reduces the overall quality of care.
- Pay and benefits for SUD service workers are not competitive when compared to other career paths available to trained social workers.
 - SUD counselors are paid less than nearly all bachelors-level health professionals.
- Access to IC&RC credential SUD counselors is more difficult in the rural regions of the state.
 - Rural providers report difficulty recruiting and retaining SUD service staff.
 - There are 37.5% fewer counselors available per 1,000 CA clients in rural CAs than all other CAs (60 counselors per 1,000 SUD admissions in rural counties compared to 96 counselors per 1,000 SUD admissions in all other counties).
- More than half of the IC&RC-certified workforce has a master's degree or higher.

We note also that over the past few years the State of Michigan has focused significant financial resources to hiring social workers to provide child welfare services.

¹ The current MDCH Bureau of Substance Abuse and Addiction Services (BSAAS)

Publicly Funded SUD Services

Michigan's publicly funded services for primary SUDs are provided through designated CAs. They serve specific geographic areas and function as gatekeepers for Medicaid beneficiaries and the uninsured, providing assessment, authorization and payment of services. CAs contract with agencies and, less frequently, with individual counselors to provide SUD treatment. In either case, each counselor serving a CA client must either be certified by MCBAP or be registered with MCBAP as having a certification development plan in place. State law requires each agency to have an active Michigan substance abuse services license through the Department of Licensing and Regulatory Affairs.

Michigan CAs do not officially collect and report the capacity of their contracted agencies or counselors. In interviews, urban CAs reported no concern with local provider ability to address increased demand because of the ACA. Urban/suburban providers reported fewer concerns in being able to recruit credentialed counselors in the future but noted high rates of staff turnover. Rural providers reported growing difficulties recruiting credentialed counselors.

The Michigan Medicaid program carves SUD treatment out of its physical health managed care program. All Medicaid beneficiaries, whether in managed care or not, must access *primary* SUD treatment through a CA. Medicaid beneficiaries who have a serious mental illness receive services from the Prepaid Inpatient Health Plan (PIHP) covering their county of residence. Where a beneficiary has a co-occurring SUD, the PIHP is the primary provider and typically does not refer the beneficiary to a CA for SUD treatment but rather provides the SUD treatment in the context of the co-occurring disorder. When this is the case, the PIHP has more flexibility than a CA to serve the client with a treatment team that does not include someone with IC&RC certification, though PIHPs require a master's degree for counselors. Nationwide, mental health treatment programs report that 20% to 50% of clients have a co-occurring SUD. In addition, the current move toward integrating mental health and SUD treatment into primary care is likely to move some beneficiaries currently seen by CAs into PIHPs or medical settings. IC&RC recently published a position paper calling for a workforce specifically credentialed in co-occurring disorders for this population. This will be a matter for Michigan Medicaid to consider, and it is a component of the future SUD service workforce.

Other Payors

Michigan residents can access SUD services through a number of additional payors including private commercial health coverage, Medicare, and the Michigan Department of Corrections. In addition, the Michigan Judiciary actively refers many people into mandated SUD treatment, which is not typically covered by insurance. There is broad discrepancy in available services, provider credentialing and licensure requirements, patient financial participation, and placement criteria among payors and across courts.

Impending Changes in the SUD Environment

Several significant changes in the administrative structure of SUD and mental health service delivery are converging and could affect access to SUD services in Michigan:

- State legislative and policy changes will reduce the number of Medicaid PIHPs and mandate the full integration of CAs into the state's PIHPs.

- The ACA authorizes expansion of Medicaid eligibility to all citizens with income below 138% of the Federal Poverty Level. By 2021, Michigan is projected to cover an additional 470,000 adults, with assumed SUD prevalence in about 90,000 individuals.
- About 515,000 Michigan residents will access private individual market health coverage through a Health Insurance Exchange. Estimated SUD prevalence in this population is about 90,000 individuals.
- In 2014, nearly all persons under court-ordered SUD treatment and/or receiving treatment through the MDOC will have access to Medicaid or an Exchange plan and a benefit for SUD treatment.
- Because federal Substance Abuse Block Grant funds for SUD services target the uninsured and many of the uninsured will be affected by coverage expansion in the ACA, the future of these funds is very uncertain.

Future Demand for Primary SUD Services

HMA sees two factors that could increase the demand for primary SUD treatment in the Medicaid population. First, availability of a benefit for SUD diagnosis and treatment where none was previously available should be expected to induce some within the expansion population to seek services. Note that individuals with an SUD that has progressed to the point of emergency are likely already CA clients under Medicaid or Community Grant funding. More importantly, if the expansion population accesses primary care and primary care is aware of the SUD service benefits and is comfortable screening and referring to SUD treatment, many more people could be referred for SUD treatment, and at an earlier point in the disease. To the extent that primary care practices are willing to screen, are adept at doing so, and refer those screened for SUD treatment early in the disease process, the demand for a larger credentialed workforce could range from moderate to dramatic.

Recruiting and Retaining IC&RC Credentialed Counselors

Michigan CAs do not officially collect and report the capacity of their contracted agencies or counselors. In interviews, urban CAs reported no concern with local provider ability to address increased demand associated with the ACA. Urban/suburban providers reported fewer concerns in being able to recruit credentialed counselors in the future but noted high rates of staff turnover. Rural providers reported growing difficulties recruiting credentialed counselors. However, HMA finds that barriers to new MSW-level counselors becoming IC&RC credentialed in the future and barriers to retaining MSW-level credentialed counselors outweigh the factors driving master's level social workers into the IC&RC credentialing process. The figure below highlights the drivers and barriers.

MSW ENTRY into Credentialed SUD Treatment Workforce	MSW RETENTION in Credentialed SUD Treatment Workforce
Drivers Passion for the field College course work in addictions Exposure to addictions field in positive light	Drivers Passion for field Job Satisfaction
Barriers Cost of credentialing process Time required for credentialing process Higher pay for human services work Higher pay for mental health work (Possible) Higher pay and no credentialing required by commercial insurers Opportunity to counsel for secondary SUD without credential Limited employee benefits <i>(Possible in the future) Higher pay and no credentialing required by commercial insurers</i>	Barriers Aging of workforce Burnout Cost of additional credentialing to become supervisor Time required for credentialing to become supervisor Higher pay for human services work Higher pay for mental health work Pay dependent on volume of clients served Limited employee benefits <i>(Possible in the future) Higher pay and no credentialing required by commercial insurers</i>

HMA believes that the flow of persons with less than a master's degree into and out of the IC&RC credentialed workforce will remain largely unchanged in the future. However, we believe that the number of master's level social workers entering and remaining in the IC&RC credentialed workforce could significantly decrease based on changes in the environment. This is likely to result in an insufficient supply of IC&RC credentialed counselors to meet the higher demand for services that will grow from health care reform.

Integration: A Possible Down Side

As noted, CAs will become fully integrated into PIHPs by October 1, 2014.

More behavioral health services are also being integrated into primary care settings, often through co-location of behavioral health counselors in primary care settings. Where this is the case, the behavioral health counselor is not required to have IC&RC certification, and rarely would.

HMA believes that while both of these integration scenarios are positive and desirable in many ways, they also both increase the likelihood that treatment for SUD will be delivered by an integrated team that has no formal training in addictions.

Recommendations

BSAAS should take steps to assure that there is an adequate workforce of IC&RC certified counselors across the state, and also to assure that as health care integration develops, all treatment teams include access to a professional trained in diagnosis and treatment of addictions.

Immediate Steps

1. Workforce Capacity Survey

BSAAS should immediately engage with Michigan's CAs to develop a survey tool to assist the state in its understanding of SUD service workforce capacity. The CAs should collect and report the following data elements to BSAAS.

- For each contracted provider, an estimate of the number of clients currently referred by the CA.
- For each contracted provider, an estimate of the number of additional clients that could be referred by the CA and assisted by current staff.
- For each contracted provider, an estimate of the number of additional clients that could be referred by the CA and assisted by new staff.

This information should be used to inform the initial measures used by BSAAS to monitor the SUD service field, as recommended.

2. Develop and deploy BSAAS leadership

Implementation of the ACA provides a new opportunity to advance the treatment of SUDs on many fronts. The MDCH should deploy new resources to assure internal capacity and leadership through BSAAS. BSAAS should take a leadership role to:

- Build public awareness of the availability of diagnosis and treatment of SUDs through Exchange plans and Medicaid.
- Advance and support early diagnosis and treatment of SUDs in the primary care setting.
- Promote detection and treatment of SUDs in primary care settings.
- Consider which IC&RC credentials are most appropriate in the emerging environment, considering:
 - Clinical supervisory credentials.
 - Credentials for managing co-occurring mental illness and SUD.
 - Credentialing licensed social workers.
- Partner with MDOC to explore use of federally matched Medicaid funds for SUD treatment of parolees and probationers.
- Educate the judicial system about the Medicaid expansions and options to draw federal funds for SUD treatment.
- Develop a statewide academic collaboration to build SUD services training into all health professions.

3. Monitor Changes in the Field

Michigan's plan to merge CAs into PIHPs affords a new opportunity to better address SUDs co-occurring with mental illness, and to develop models for the most efficient use of IC&RC-credentialed counselors and supervisors, peer-support personnel, and mental health practitioners in a team approach. HMA believes that much of this could occur "under the radar" in ways that are not readily observable or measureable under current reporting requirements. BSAAS should pro-actively establish a "surveillance

model” of specific measures before this change is implemented. Measures should carefully monitor changes in the portion of clients deemed primary SUD and those with co-occurring mental illness, who is providing their SUD treatment, and the credentials of the treatment team members. Measures should include:

- Capacity of CA provider networks to accept additional clients by type of service.
- More complete MCBAP data on the demographics of counselors, credentialed and in development plans, and regular reports on selected measures.
- Clients served by teams that have no IC&RC credentialed members.

Long Term Recommendations

1. Raise Reimbursement for SUD Services

MDCH and the legislature should recognize that an increase in SUD reimbursement rates targeted to the pay and benefits of direct care staff would effectively mitigate many of the problems in assuring an adequate workforce identified in this report. Through a Medicaid expansion as specified in ACA, the state can increase payment rates for the new population and receive 100% federal match. Although the same increased payment rates must apply to the current Medicaid population as well, which would increase program expense, the net effect may be fairly small. Medicaid should carefully consider this strategy.

2. Recruit New IC&RC Credentialed SUD Service Workers

The challenges in recruiting IC&RC-credentialed workers are significant and require concerted effort to overcome. Michigan should:

- Adopt some of the strategies used by the nursing profession in characterizing, advertising, and correcting nursing shortages.
- Develop awareness among high school and college students, especially minorities, about the SUD service field and how counselors positively change lives.
- Develop tuition reimbursement and loan forgiveness strategies, especially for shortage areas.
- Identify opportunities to assure completion of IC&RC development plans.
- Update healthcare workforce shortage information on Michigan’s LARA Health Careers website.
- Develop a statewide, integrated strategy to connect college, university, and community college health career programs with CAs and SUD service providers for academic rotations, internships, and externships.

3. Retain Credentialed SUD Service Providers

Challenges in retaining IC&RC-credentialed counselors are significant; poor pay and benefits compared to other opportunities, a lack of career ladder opportunities, and professional burnout are endemic. The MDCH should challenge PIHPs and CAs to develop full-time employment opportunities for SUD counselors that include benefits, subsidies for continuing education requirements, and career development options.

4. Extend the Capacity of Credentialed SUD Counselors

As noted, credentialed SUD counselors are in short supply in Michigan's rural communities. If the demand for SUD treatment grows with Medicaid expansion, the supply could be strained in other communities too. Michigan should adopt measures to extend the capacity of the SUD service workforce for rural areas immediately and also be prepared to use the measures where other shortages emerge. All of the following would "stretch" the ability of the current credentialed workforce to serve more clients.

- Use telehealth to deploy SUD counselors in well-staffed locales to rural areas.
- Allow IC&RC-credentialed counselors to work in an advisory capacity to another non-credentialed counselor.
- Allow an IC&RC-credentialed counselor to serve as a member of or advisor to the larger treatment team.

5. Support Integrated Care Treatment Models That Assure Access to Consultation and Support from IC&RC Certified Counselors

As BSAAS monitors changes resulting from merging CAs and PIHPs, and from better integration of behavioral health and primary care, it should lead efforts to codify and require models for the most efficient use of IC&RC-credentialed counselors and supervisors, peer-support personnel, and mental health practitioners in a team approach. This would likely include the use of IC&RC-credentialed counselor as members of, or advisors to, larger integrated treatment teams.

Introduction

The Michigan Department of Community Health (MDCH) Bureau of Substance Abuse and Addiction Services (BSAAS) engaged Health Management Associates (HMA) to assess the ability of the current public safety net system to meet the substance abuse disorder (SUD) and addiction treatment needs of the expanded population eligible for the Medicaid expansion authorized in the Affordable Care Act (ACA). The assessment was to include:

- An estimate of current number of individuals with SUDs unable to receive treatment within the public safety net.
- An estimate of the number of individuals to be added to public and private systems by the ACA, under the Health Insurance Exchange and possible Medicaid expansion.
- A review of current providers of Medicaid reimbursed services , including:
 - Credentialing issues
 - Training needs
 - Administrative capacity
- Consideration of the role of the state's Prepaid Inpatient Health Plans (PIHPs) in providing SUD treatment.
- Medicaid coding issues in SUD services.
- SUD service provider licensure and certification requirements by payor.
- The salary and benefits of SUD counselors in CAs compared to others.
- The effect commercial carriers seeking capacity to treat SUDs for the newly insured will have on the public system SUD service workforce.
- Other relevant features of the SUD treatment environment.

In order to make this assessment, it is necessary to understand the credentialing requirements for SUD counselors, since these requirements have an important influence on the quality and quantity of SUD counselors. It is also imperative to consider the broader environment in which SUD service is addressed by commercial insurance and the justice system, because it, too, will change under the ACA and will more directly intersect the safety net system. We begin, therefore, with a discussion of these credentialing requirements, move then to explore the nature of the current workforce, and from there to a discussion of the current environment for the provision of SUD services and how this environment is likely to change because of the implementation of various legislative initiatives at the state and federal level.

HMA conducted extensive interviews with policy makers, CAs, credentialing bodies, counselors, PIHPs, consumers, associations, and staff of MDCH and the Michigan Department of Corrections (MDOC).² We reviewed literature and data on national and state trends in the SUD treatment workforce, pay rates, and SUD service provider certification in Michigan, along with estimates of the prevalence of SUDs expected in the expansion populations. We analyzed trends in funding and treatment numbers in the

² A complete list of individuals and organizations interviewed is found as Attachment 1

CAs over a decade and reviewed literature on the cost benefit of treating SUD. For consistency, our analysis and recommendations presume that Michigan will expand Medicaid under the provisions of the ACA, though a final decision has not yet been made.

This report presents:

- Background on the national and Michigan requirements for SUD counselors.
- Key demographics of the current SUD service workforce serving publicly funded clients.
- Michigan's SUD service environment by payor including provider requirements, budgets and level-of-care decisions for:
 - Medicaid through CAs
 - Medicaid through PIHPs
 - Commercial insurance carriers
 - Medicare
 - Michigan Department of Corrections
 - Courts/court-ordered treatment
 - Private pay
- Discussion about the impending changes to the SUD treatment environment including the impact of known and unknown secondary effects associated with implementation of the ACA on the SUD service workforce.
- Projections of future SUD service workforce shortages.
- Recommendations intended to assure a sufficient and robust SUD service workforce.
- Attachments illustrating relevant trends and other factors in the SUD service arena.

Background on SUD Treatment Environment

In Brief

- *Michigan's implementation of the Federal Affordable Care Act could provide many residents with new access to SUD treatment services.*
- *Research suggests that effective investment in expansion of SUD treatment services could reduce state expenditure for criminal justice services, physical health services, and assistance payments to low income and disabled individuals.*
- *SUD counselors paid through Coordinating Agencies are required to meet the accreditation standards established through the International Certification & Reciprocity Consortium (IC&RC).*

Background

Worldwide, substance abuse has gained attention for the damage it does to individuals, families, and communities. In the United States, mental health and SUD treatment and services are increasingly integrated into the primary care treatment system. Both the ACA and President Obama's National Drug Control Strategy have the potential to transform how SUD treatment is practiced, as treatment for SUDs is extended to more than 30 million Americans. As these initiatives are being implemented, the need for trained and experienced addiction and prevention professionals is growing. According to the U.S. Department of Labor, substance abuse counseling is one of the fastest growing professions, projected to grow 27 percent by 2020.³

Research has identified a positive correlation between alcohol and drug abuse and increased public expenditure for criminal justice; hospital and emergency room health services; infectious disease efforts against HIV/AIDS, hepatitis and tuberculosis; and payments through social assistance programs like unemployment, cash assistance, disability, and food assistance. A 2005 cost-benefit analysis published in the journal *Health Services Research* found that a payment of less than \$1,600 for substance abuse treatment services produced societal benefits of nearly \$11,500 (a benefit-cost ratio of greater than 7:1).⁴ Many subsequent studies have quantified the cost-benefit ratios of treating SUD. For example, in 2010, the Colorado Medicaid program calculated a benefit-cost ratio of 2.2:1 in reduced Medicaid cost when Medicaid provides treatment for SUD.⁵

The adequacy of the size of the SUD service workforce to meet impending demands is a serious concern of state and national policy makers. The U.S. Department of Health & Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) is the chief federal agency addressing all aspects of SUD prevention and treatment. In 1993, SAMHSA's Center for Substance Abuse Treatment (CSAT) funded the Addiction Technology Transfer Center (ATTC) network as a nationwide, multidisciplinary

³ U.S. Department of Labor, Bureau of Labor Statistics, March 2012 <http://www.bls.gov/ooh/community-and-social-service/substance-abuse-and-behavioral-disorder-counselors.htm>

⁴ Benefit-Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment "Pay for Itself?" Ettner, S., et al, *Health Services Research* 41:1 February 2006

⁵ Medicaid Outpatient Substance Abuse Treatment Benefit, Department of Health Care Policy and Financing Performance Audit, November 2010 [http://www.leg.state.co.us/OSA/coauditor1.nsf/All/80EE029745B4C589872577F30060F888/\\$FILE/2079SubstanceAbuseFinalReport12132010.pdf](http://www.leg.state.co.us/OSA/coauditor1.nsf/All/80EE029745B4C589872577F30060F888/$FILE/2079SubstanceAbuseFinalReport12132010.pdf)

resource for professionals in the addictions treatment and recovery services field to raise awareness of evidence-based and promising treatment and recovery practices.⁶ The goals of the ATTC include building skills to prepare the workforce to deliver state-of-the-art addictions treatment and recovery services and changing practices by incorporating these new skills into everyday use for improving addictions treatment and recovery outcomes. In October 2012, ATTC released its long-awaited report, *Vital Signs: Taking the Pulse of the Addiction Treatment Profession*, prepared for SAMHSA.⁷ It calls for improving monetary compensation, healthcare benefits, and access to continuing education to increase the number of professionals entering and staying in the field.

National and International Credentials and Standards

The IC&RC has established standards and facilitated reciprocity for the credentialing of addiction-related professionals since 1981. Today, IC&RC represents 76 member boards, including 24 countries, 47 U.S. states and territories, all branches of the U.S. military, and 5 Native American territories. IC&RC sets international standards for competency-based certification programs through testing and credentialing of addiction professionals. More than 45,000 professionals are credentialed by IC&RC, including about half of U.S. substance abuse treatment professionals. It offers the following credentials:

- Certified Advanced Alcohol and Drug Counselor (CAADC)
- Certified Alcohol and Drug Counselor (CADC)
- Certified Clinical Supervisor (CCS)
- Certified Co-Occurring Disorders Professional (CCDP)
- Certified Co-Occurring Disorders Professional-Diplomat (CCDP-D).
- Certified Advanced Alcohol and Drug Counselor (CAADC)
- Certified Prevention Specialist (CPS/CPC-R)
- Certified Criminal Justice Professional (CCJP)

The IC&RC supports a career ladder for prevention, treatment, and recovery professionals but asserts that credentialing must accommodate all levels of education and clinical practice. IC&RC credentials offer a pathway for advancement for entry-level individuals and for advanced practitioners. An individual may enter the credentialing process with any background, from no college to a master's degree. The required number of educational contact hours is the same regardless of the candidate's background, but required hours of supervised work vary widely. This approach assures that persons in recovery, regardless of background, can become certified addictions counselors, providing an important element of peer support to the workforce.

While IC&RC offers reduced supervised work requirements for master's-prepared counselors, all seeking certification—physicians and master's-prepared psychologists, nurses, and licensed social workers—must complete 2,000 hours of supervised SUD treatment to become a CADC.

⁶ http://www.attcnetwork.org/documents/overview_of_the_attc_network.pptx

⁷ <http://www.attcnetwork.org/documents/VitalSignsReport.pdf>

The IC&RC also contends that in the climate of integrating SUD services into the larger mental health field, it is very important that professionals treating clients with co-occurring mental health and SUDs have competency in the interaction of SUD and mental illness.

The National Association of Alcoholism and Drug Abuse Counselors (NAADAC) is also involved in assuring a competent SUD service workforce. Founded in 1974, NAADAC represents the nation's 75,000 addiction counselors, educators, and addiction-focused health care professionals. NAADAC provides education and clinical training and national certification for Certified Addiction Counselor, Nicotine Dependence Specialist, and Master's Addiction Counselor. NAADAC has credentialed more than 15,000 counselors.

Michigan Credentialing Standards

Prior to 2003, the state required CAs to ensure that individuals treating SUDs had passed a Fundamentals of Alcohol and Other Disorders Professional test. The state dropped the requirement in 2003, when the test became outdated. In 2005, the Office of Drug Control Policy (ODCP)⁸ reached a tentative decision to support an existing nationally accepted credential that addressed both treatment and prevention. A workgroup was established to consider operational issues associated with this policy, and in October 2006 ODCP released its report. It recommended that IC&RC credentials be endorsed by MDCH/ODCP. However, it also recommended that comparable and equivalent credentials be accepted as well and allowed Michigan-specific and IC&RC provisions for grandfathering of certain counselors.

The report also recommended consideration of reimbursement rates that would support increased compensation subsequent to new credentialing requirements, that staff training be made available by the state, that diversity and geographic workforce considerations be explored, and that Michigan foster relationships with universities to develop addiction-specific curricula. These recommendations were not formally adopted.

Beginning in the late 1970s, Michigan counselors became certified through the Michigan Department of Public Health. This function was transferred to an independent non-profit organization, the Michigan Certification Board for Addiction Professionals (MCBAP), in the 1990s. MCBAP maintains records of certified counselors, administers certification tests, makes continuing education opportunities available to counselors, manages the provider development plan process, and adjudicates ethics complaints against certified counselors. MCBAP allows SUD counselors without IC&RC certification to work under supervision for up to three years, during which the counselor is engaged in a formal "development plan" to obtain certification.

Some professionals in the social work field and licensed SUD treatment agencies are suggesting that licensed social workers who provide counseling services, most of who are master's prepared, have sufficient expertise to counsel persons with SUD without the additional lengthy and costly IC&RC certification. However, there are currently no requirements that Michigan's Schools of Social Work require or even offer any course work in addictions, and at least one program offers no such courses.

⁸ The current MDCH Bureau of Substance Abuse and Addiction Services (BSAAS)

Michigan's IC&RC Credentialed Workforce

In Brief

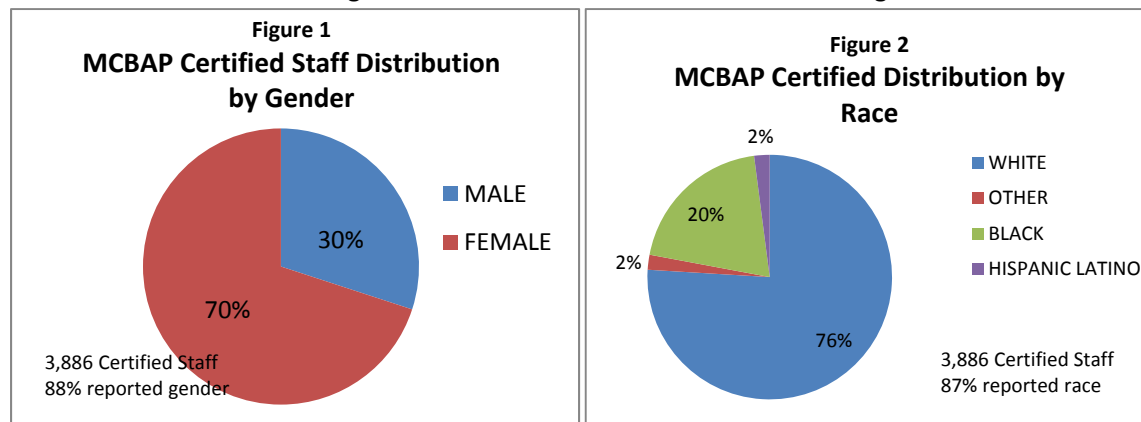
- Michigan's credentialed SUD service workforce mirrors the nation's in being heavily female and having limited diversity.
- Turnover in the SUD service workforce is very high and is attributable to poor pay, high stress, and training/continuing education requirements that are costly and time consuming.
- Pay and benefits for SUD service workers are not competitive when compared to other career paths available to trained social workers.
- Access to IC&RC-credentialed SUD counselors is more difficult in the rural regions of the state. Providers report difficulty in recruiting and retaining SUD service staff.

Demographics

The ATTC (national) data show the average age of SUD clinical directors is 52 years, and 60% are age 50 or more. Cultural diversity is lacking, as the majority of members of the SUD service workforce are white and female. One-third of the national SUD service workforce is in recovery.⁹

MCBAP retains data from its applicants. The application form includes optional entries for applicant age, salary, gender, and ethnicity. Optional data fields result in data being incomplete for many applicants.¹⁰ Below is some general information about the population currently certified by IC&RC to provide SUD treatment services. While HMA could not evaluate age or recovery status, the gender and ethnic demographics parallel the national SUD service provider workforce.

Figures 1 and 2 show that the large majority of Michigan's *certified* SUD counselors are female, and minorities account for less than one-quarter of certified SUD treatment professionals. Figures 3 and 4 show SUD counselors in a development plan and suggest small shifts in the demographic make-up; the profession continues to attract females at a far higher rate than males, but minority participation is 30% compared to just 24% among credentialed counselors. As seen in Figure 5, more than 80% of individuals with a development plan are working towards certification as addiction counselors. Figure 6 illustrates that more than half of Michigan's certified workforce have a master's degree or a Ph.D.



⁹ "Vital Signs – Taking the Pulse of the Addiction Treatment Profession," SAMHSA September 28, 2012

¹⁰ Appendix X includes all MCBAP demographic data HMA obtained for this study.

Figure 3
MCBAP Development Plan
Distribution by Gender

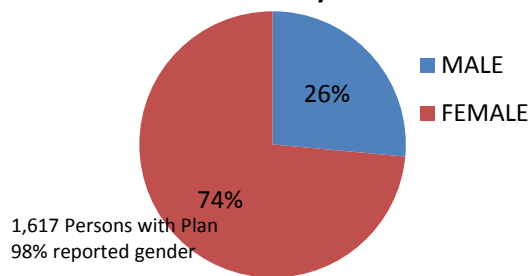


Figure 4
MCBAP Development Plan by Race

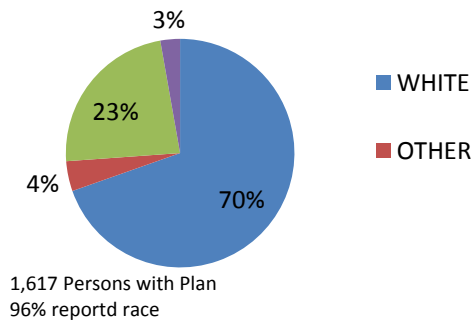


Figure 5
MCBAP DISTRIBUTION OF DEVELOPMENT PLAN BY TYPE
N = 1,617

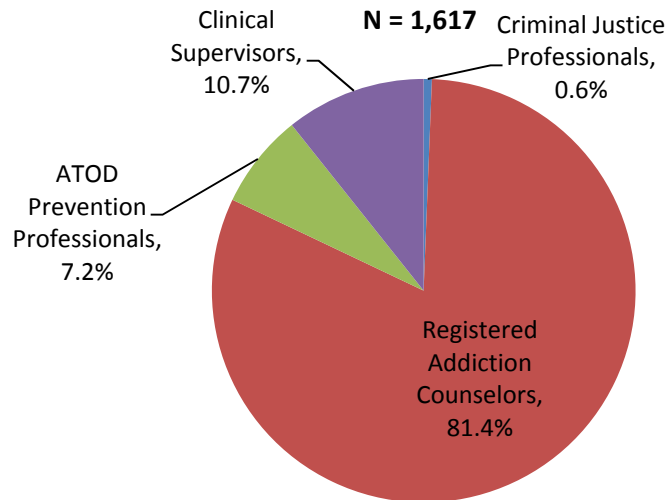


Figure 6
MCBAP CERTIFIED COUNSELORS: EDUCATION ATTAINMENT
N = 3,886

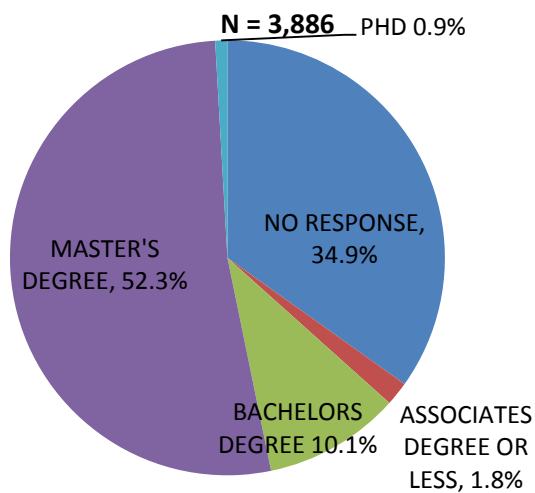


Table 1 shows the total number of MCBAP-certified counselors and those with a MCBAP approved IC&RC development plan, by rural and all other counties.¹¹ Access to SUD counselors in rural CAs is more limited than elsewhere. There are 37.5% fewer counselors per 1,000 CA clients in rural CAs than in non-rural CAs (60 per 1,000 SUD admissions in rural counties compared to 96 per 1,000 SUD admissions in all other counties). This difference in availability is more significant because of the greater geographic distances between available counselors. Over two-thirds of Michigan's counties (57 of 83) are federally designated as rural, but these counties account for less than 19% of Michigan's population.

Table 1 Michigan SUD Counselors, MCBAP October 2012							
	2010 POPULATION	TOTAL CA CLIENTS	CERTIFIED COUNSELORS	DEVT. PLAN COUNSELORS	TOTAL COUNSELORS	COUNSELORS PER 1,000 CLIENTS	% OF COUNSELORS ON DEVT. PLAN
RURAL COUNTIES	1,849,724	17,258	760	273	1,033	60	26%
ALL OTHER COUNTIES	8,027,419	48,877	3,348	1,337	4,685	96	29%
TOTAL	9,877,143	66,135	4,108	1,610	5,718	86	28%

Note: includes all certification categories

Absent some unforeseen change, the shortage of counselors in rural counties will not be overcome in the near future. Data show that the ratio of staff per 1,000 clients under an IC&RC development plan (a proxy in our analysis for younger, less experienced staff) is similar, if not a bit smaller, in rural counties. Thus, ease of access will continue to depend on where a client lives. In many rural counties across the country, there is also a relative shortage of primary care providers, and so they cannot serve as a secondary safety net to provide diagnosis, education, and prevention services for people with a SUD.

In general, Michigan's CAs report that their clients face few barriers to accessing SUD treatment, and that contracted providers have sufficient staff and capacity to serve CA clients. However, SUD service providers have a different perspective and report challenges in recruiting and retaining credentialed staff. Providers serving rural communities reported greater difficulty in recruiting and retaining staff and expressed greater pessimism about the capacity to meet future workforce demands. HMA notes that the "disconnect" between the CAs and the providers who serve CA clients is significant and pervasive. MDCH typically turns to CAs for information even though it would almost certainly be beneficial to query providers as well to get a more complete and balanced assessment.

Pay, Recruitment, and Retention of SUD Counselors

Nationally, and in Michigan, most IC&RC SUD counselors work as independent contractors to a licensed agency or public entity. Contracted positions are not eligible for employee benefits and pay is completely dependent on fees for services delivered. Compensation is dependent on referrals and is subject to client "no-shows." Pay scales for SUD counselors are among the lowest in the health care field. Table 2 illustrates that in Michigan, SUD counselors are paid well below mental health clinicians, though both have a master's degree and the SUD counselor are required to undergo extensive additional training.

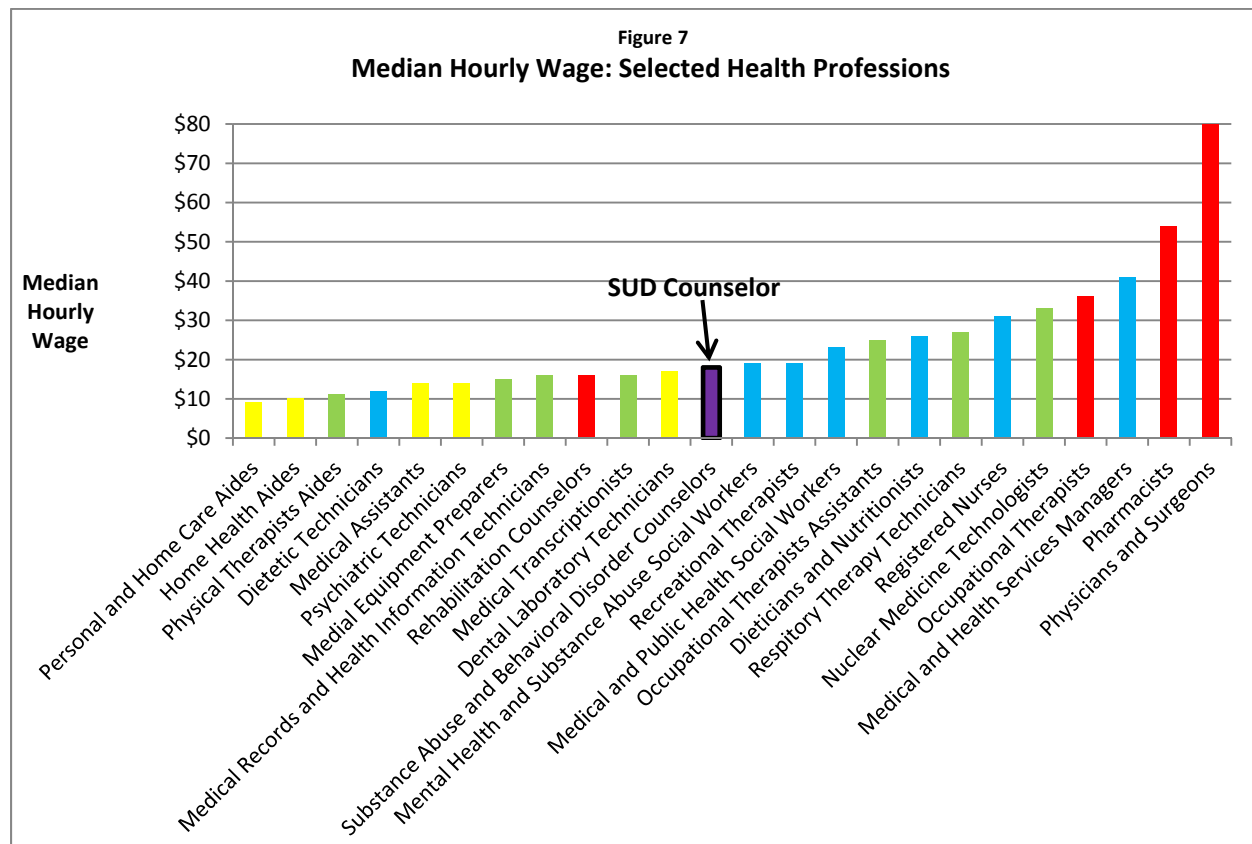
¹¹ HMA developed the county definitions, which are described in Attachment 2

Table 2 Comparison: Michigan Pay and Benefits for Master's Level SUD and Mental Health Counselors				
	Annualized Salary	Pay Basis	Employment Status	Benefits
Mental Health Clinician*	\$50,606	Hourly	Employed	Yes
Certified Alcohol & Drug Counselor**	\$43,400	Per Client	Contracted	No

* Source: Michigan Association of Community Mental Health Boards 2011 Salary and Benefits Survey

** MCBAP Data Base

Figure 7 illustrates median hour wage for various health professions. SUD counselors, more than half of whom, have master's degrees, are paid less than nearly all bachelors-prepared professionals.



High School or Below	Yellow
Associates	Green
Bachelors	Blue
Master's or Above	Red

Nationally, the annual turnover in master's-prepared certified SUD service workers is 18.5%. High attrition rates are attributed to job stress and better opportunities for pay and advancement in other behavioral health or social work settings. In Michigan, stakeholders throughout the system report that the expenses SUD service workers incur to obtain and maintain IC&RC certification is not balanced with commensurate pay, benefits, or career opportunity, and that workforce turnover is very high. Licensed

social workers, in particular, leave the SUD service arena to work in mental health. Increasingly, social workers are moving to Michigan's child welfare arena.¹² High workforce turnover is undesirable on many levels: it disrupts continuity of patient care, adds significant expense to the system in training costs, and reduces the overall quality of care.

Figure 8 shows the factors that drive master's-level social workers to enter and to stay in the workforce of IC&RC credentialed counselors. There are few drivers and many barriers.

Figure 8 Drivers and Barriers to Recruiting and Retaining Credentialed SUD Counselors

MSW ENTRY into Credentialed SUD Treatment Workforce	MSW RETENTION in Credentialed SUD Treatment Workforce
Drivers Passion for the field College course work in addictions Exposure to addictions field in positive light	Drivers Passion for field Job Satisfaction
Barriers Cost of credentialing process Time required for credentialing process Higher pay for human services work Higher pay for mental health work (Possible) Higher pay and no credentialing required by commercial insurers Opportunity to counsel for secondary SUD without credential Limited employee benefits <i>(Possible in the future) Higher pay and no credentialing required by commercial insurers</i>	Barriers Aging of workforce Burnout Cost of additional credentialing to become supervisor Time required for credentialing to become supervisor Higher pay for human services work Higher pay for mental health work Pay dependent on volume of clients served Limited employee benefits <i>(Possible in the future) Higher pay and no credentialing required by commercial insurers</i>

HMA expects that the number of IC&RC credentialed counselors who both enter and remain in the workforces who have a bachelor's degree or less higher education is not subject to many of the impending changes in the SUD service environment, and will not change dramatically. However, we believe that the combination of impending changes in the environment with the barriers to recruiting and retaining master's-level social workers will reduce the workforce. Fewer MSWs will seek the IC&RC credential, and more will leave the field or seek opportunities to counsel persons with SUD where the credential is not required.

¹² Michigan's Department of Human Services and private child placing agencies have been aggressively hiring staff to meet the case-to-worker ratios mandated in the modified child welfare settlement agreement reached with the Children's Rights advocacy organization.

Michigan's SUD Treatment Environment

In Brief

- *Over the past few decades, SUD treatment has been increasingly focused on outpatient and intensive outpatient services. Individuals have far less access to hospital-based SUD services, and the average length of stay for hospital placements has fallen dramatically.*
- *Publicly funded SUD services are provided through designated Substance Abuse Coordinating Agencies (CAs). CAs are provided a fixed allocation for Medicaid and Community Grant clients each year. Decisions about the intensity of placements, especially for Community grant services, can be influenced by a CA's financial constraints.*
- *Outside the public SUD service system, Michigan residents can access SUD services through a number of additional payors including Medicaid mental health services, private commercial health coverage, Medicare, the Michigan Department of Corrections. In addition, the Michigan Judiciary actively refers many people into mandated SUD treatment, which is not typically covered by insurance. HMA identified broad discrepancy in available services, provider credentialing and licensure requirements, patient financial participation, and placement criteria among payors and across courts.*

The Service Continuum in Michigan

A broad continuum of services is offered to persons with SUD, ranging from early intervention through long-term residential care for those with the most advanced disease. Figure 1 illustrates, in general terms, the treatment modalities available to all payors, though not all payors cover all modalities. Over the past two decades, SUD treatment has moved away from long-term residential care and to greater use of outpatient and intensive outpatient care. Currently far fewer providers offer short-term residential services and the average length of stay for hospital-based SUD services has fallen dramatically over the previous decade. Further, there are fewer methadone providers, especially in rural areas. Today's SUD service delivery system is not well integrated with services provided for co-occurring mental health or physical health disorders. This is changing, however, as the state takes steps to integrate behavioral health into primary care practice and works to further consolidate the administration of mental health and SUD services through the PIHPs.

SUD Payors and Populations

Michigan Medicaid – Primary SUD

The Michigan Medicaid program carves SUD treatment out of its physical health managed care program. All Medicaid beneficiaries, whether in managed care or not, must access *primary* SUD treatment through a CA.

There are currently 16 CAs in the state. They serve specific geographic areas and function as gatekeepers for Medicaid beneficiaries and the uninsured, providing assessment, authorization, and payment to contracted providers. Nine CAs have merged with PIHPs; some stand alone; and some are housed within local public health departments. Regardless, all CAs are funded and administer services in generally the same manner.

CAs contract with agencies and, less frequently, with individual counselors. In either case, each counselor serving a CA client must either be certified by MCBAP or be registered with MCBAP as having

an approved development plan in place.¹³ State law requires each agency to have an active Michigan substance abuse service license through the Department of Licensing and Regulatory Affairs. Individuals licensed to provide medical or psychological services (psychiatrists, psychologists, licensed social workers) operating an individual practice may provide substance abuse services without a substance abuse service license.

CAs receive an annual capitated allocation, managed through the associated PIHP, for Medicaid SUD services. Unused allocations are returned to the PIHP. Medicaid prohibits CAs from operating with a waiting list. Functionally this means, according to CAs and SUD counselors, that individuals will be offered some level of care once they request assistance from a CA. For example, a CA may not have a detox bed available but will offer outpatient SUD services to a client until a bed is available. CAs must take into account waiting list requirements and budgetary status when they make level-of-care decisions, while also adhering to national placement criteria set forth by the American Society of Addiction Medicine (ASAM). As a result, clients may receive differing levels of service depending on when they present to the CA and what level of service has an opening or a bed available. This practice occurs across the nation and reflects the lack of adequate funding for SUD treatment at numerous levels of care.

Michigan Medicaid – SUD Co-Occurring with Mental Illness

Medicaid beneficiaries who have a serious mental illness receive services from the PIHP that covers their county of residence. There are currently 18 PIHPs in the state. PIHPs screen clients and may provide some services directly. Most often, PIHPs contract with local Community Mental Health Service Providers (CMHSPs) to provide authorized services. Where a beneficiary has a co-occurring SUD, the PIHP is the primary provider and typically does not refer the beneficiary to a CA for SUD treatment but rather provides the SUD treatment in the context of the co-occurring disorders. When this is the case, the PIHP has more flexibility than a CA to serve the client with a treatment team that may not include someone with IC&RC certification. PIHPs do, however, require a master's degree for counselors. Nationwide, mental health treatment programs report that 20% to 50% of clients have a co-occurring SUD.¹⁴ The current move toward integrating mental health and SUD treatment into primary care is likely to move some of beneficiaries seen by CAs into PIHPs or medical settings. IC&RC just published a position paper calling for a workforce specifically credentialed in co-occurring disorders for this population. This will be a matter for Michigan Medicaid to consider, and it is a component of the future SUD service workforce.

The Uninsured

The State of Michigan receives federal Substance Abuse Block Grant dollars through SAMHSA to provide SUD services to the uninsured. These funds along with State General Fund dollars are referred to as "Community Grant Funds;" the funds are allocated to Michigan's CAs through an established formula. Services are provided through the same contracted provider network that serves Medicaid clients, so counselors are IC&RC-certified. The Community Grant budget is supposed to last for the fiscal year, and

¹³ Development plans must be completed within three years

¹⁴ SAMHSA Center for Substance Abuse Treatment, 2005

CAs report that Community Grant funds are almost always fully expended. As with Medicaid clients, treatment decisions for Community Grant clients are dependent on how much of the budget remains and whether the optimal service is available. Allocating a fixed amount to CAs creates an incentive for them to more heavily utilize lower-cost services as the fiscal year progresses and the available Community Grant funds run low. This is a phenomenon observed in public mental health systems in other states—reliance upon lower-intensity services to ensure access to a fixed allocation over a full year.

The Public System's Move to a Recovery-Oriented System of Care

Michigan's PIHPs, CAs, and their contracted providers make up the state's public behavioral health system, which serves Medicaid and the uninsured. The entire system has been undergoing a concerted move to become a Recovery-Oriented System of Care. This has been the priority of SAMHSA/CSAT since the Bush (43) administration (President's New Freedom Commission). Michigan's Recovery-Oriented System of Care is designed to move away from acute, episodic treatment of SUD and instead support an individual's journey toward recovery and wellness by creating and sustaining networks of formal and informal services and supports. The use of peer supports, community services, and emerging evidence-based practices all have implications for the size and scope of the state's future certified SUD service workforce.

Commercial Plans

Commercial health insurance plans sponsored by employers are required to provide behavioral health services at parity with physical health services in all plans where behavioral health is provided as a covered benefit. Many carve out SUD services to a contracted vendor that provides gate keeping and a provider network. In general, Michigan's commercial plans and/or the gatekeepers contract with licensed agencies to provide SUD services. Some also contract with individual counselors and typically require master's-level training or beyond. In Michigan, commercial plans do not specifically require that individual counselors be IC&RC-certified in SUD services. Commercial plans tend to treat SUDs in an episodic manner and have not made strides towards recovery-oriented services.

Medicare

Medicare covers SUD treatment, but does not require that counselors be certified in SUD treatment. The following health professions, acting within their scope of practice are authorized to provide SUD services to Medicare enrollees:

- Physicians
- Clinical psychologists
- Clinical social workers (Master's / Doctoral level)
- Nurse practitioners
- Clinical nurse specialist (Master's level)
- Physician assistant

Michigan Department of Corrections

The MDOC provides SUD treatment to its parolees and to persons on felony probation. It contracts with service providers across the state through a competitive process that is re-bid every three years. In FY

2012, MDOC provided residential (including detox) services to 2,916 clients, outpatient services to 5,791 clients, and residential aftercare/transitional housing to 399 clients. MDOC has historically preferred to use IC&RC-certified counselors but has not required certification. CAs have a strong perception that MDOC has significantly lower standards for service providers than they actually do. Effective October 1, 2012, MDOC required that all counselors be IC&RC-certified. Many of MDOC's contracted providers overlap with CAs. A list of overlapping contractors is included as Attachment 3.

In comparison to CAs and commercial plans, MDOC tends to make heavy use of residential treatment. Also, while MDOC uses ASAM criteria for placement decisions, multiple admissions, and longer lengths of service are common and much more frequent than seen in the Medicaid, commercial, and uninsured populations. This reflects MDOC's priority to avoid re-incarceration, so they make more aggressive use of residential care.

A number of MDOC clients are served through CAs, though many are not. In FY 2011, 35% of CA clients self-reported involvement with the MDOC at the time of admission or transfer.

Court-Ordered Treatment

The state's courts often impose mandatory SUD treatment requirements on persons charged with a wide variety of alcohol or drug related offenses. In addition to local courts, there are 113 drug courts operating across the state. Courts vary widely in the preferred providers to whom they refer clients and in the manner in which they decide what services are required.

With respect to level-of-care decisions, some courts have relationships with CAs and use them to assess the offender and make level-of-care recommendations based on ASAM criteria. Other courts decide themselves what level of service an individual needs. With respect to referral to a treatment provider, courts are free to develop their own preferred providers and to encourage or require offenders to use those providers. A court is likely to prefer providers that comply with court dates, document submittal, and other administrative priorities; consideration of the level of SUD service training of the staff is a lower priority. There are no formal data on court-preferred providers.

The single commonality across court-ordered treatment is that placement decisions do not depend on the availability of a source of payment/benefit; offenders are expected to pay for court-ordered treatment. In addition, most commercial plans do not cover court-ordered treatment.

A relatively small proportion of court-affiliated clients are served through CAs. In FY 2011, 13% of CA clients self-reported involvement with courts at the time of admission or transfer, and three percent reported involvement with a drug court.

Self-Pay

Some individuals needing treatment for SUDs are uninsured but do not qualify for public services because their incomes are too high. Others are insured but prefer not to use coverage because of concerns about confidentiality. These individuals can choose any provider, regardless of licensure or SUD service certification.

Impending Changes in the Michigan SUD Environment

In Brief

- *Changes in the administrative structure of SUD and mental health service delivery could affect access to SUD services. In the coming years, legislative and policy changes will reduce the number of Medicaid PIHPs and mandate the full integration of CAs into the state's Community Mental Health Services Program system.*
- *The Affordable Care Act authorizes expansion of Medicaid eligibility to all citizens with income below 138% of the Federal Poverty Level (FPL). Michigan has not yet made a determination about whether to implement the Medicaid expansion, nor has it decided on an expansion benefit plan. Expansion of Medicaid eligibility could dramatically increase the number of individuals with SUD treatment services as a covered benefit.*
- *Additional Michigan residents will access private individual market health coverage through a Health Insurance Exchange. The structure of Michigan's Exchange and the demographics profile of Michigan residents accessing coverage through the Exchange will be influenced by policy decisions not yet made, by the state and federal governments.*
- *In 2014, nearly all persons currently receiving SUD treatment covered by the Michigan Department of Corrections would be Medicaid-eligible under a state expansion.*
- *In 2014, nearly all persons under court-ordered SUD treatment will have access to Medicaid (assuming an ACA expansion) or an Exchange plan and a benefit for SUD treatment.*

Public Delivery System Changes

Two significant changes are underway that will alter the structure of Michigan's public behavioral health system. First, MDCH intends to reduce the number of PIHPs from 18 to 10, through consolidation of existing PIHPs and re-aligning borders. The consolidation will occur January 1, 2014, as the state awards contracts for managed Specialty Supports and Services.

Next, Michigan intends to further integrate SUD treatment into the public mental health service delivery system. In December 2012, the Legislature mandated consolidation of Substance Abuse CAs into Michigan's PIHPs. The consolidation of CAs into PIHPs will likely drive the following changes in the SUD service delivery system:

- Streamlined and consolidated administration of SUD services and possible reduction in the administrative expense to provide SUD services.
- Subsequent extension of Community Grant and Medicaid funds for additional treatment or higher reimbursement.
- Increased ability of PIHPs to use team-based care for primary and co-occurring SUD treatment, enabling credentialed SUD counselors to "stretch" to serve more clients.

Health Insurance Exchange Population

It is estimated that over 500,000 Michigan residents have incomes at 139% to 400% of the Federal Poverty Level and therefore will have access to subsidized health insurance through the Health Insurance Exchange required by the ACA. SAMHSA projects that nearly 515,000 individuals will obtain insurance through Michigan's Exchange, and that nearly 88,000 (17.1%) will have an SUD. (Table 3)

A small number of this population is probably receiving SUD services through CAs under Community Grant funds. Under the ACA, health insurance plans sold on an Exchange must cover treatment for mental health disorders and SUDs, and behavioral health benefits must have parity with physical health benefits. This will likely create new demand for SUD services and provide new opportunities for SUD providers to access new populations seeking treatment. Though commercial plans do not currently require that SUD counselors be IC&RC-certified, it is possible that in an effort to recruit a sufficient SUD service provider network, commercial insurance reimbursement rates will rise and induce SUD counselors from the public sector to “jump ship,” resulting in fewer credentialed SUD counselors serving Medicaid.

Table 3	
Estimated Prevalence of SUD Michigan Subsidized Exchange Population* Adults Age 18 - 64	
Total Adults Eligible for Exchange	514,600
Estimated Prevalence of SUD	17.1%
Estimated Number with SUD	87,997
Source: SAMHSA National Survey of Drug Use and Health 2008 - 2101 data	
* Income 139 -399% Federal Poverty Level	

Medicaid Expansion

The ACA authorizes the expansion of Medicaid services to all individuals with income below 138% FPL. If Michigan were to implement this expansion, it would mean the addition of nearly 530,000 adults into Michigan’s Medicaid program. This would represent nearly a 75% increase in Medicaid-covered adults in Michigan. As yet, Michigan has not made a determination about whether to implement the expansion of Medicaid.

The ACA provides states some flexibility in defining the health benefit available to a Medicaid expansion population. States can provide their current Medicaid plan, or can benchmark Medicaid benefits against either an existing Blue Cross Blue Shield PPO product, a health plan currently available to state employees, or the largest commercial HMO product available in the state. In Michigan, each of these plans provides inpatient and outpatient SUD treatment benefits. Further, parity requires that these benefits mirror physical health benefits and therefore not be limited in the number of medically necessary visits, the frequency of medically necessary treatment, etc. While not completely clear yet, parity may also significantly expand the current Medicaid managed care plan behavioral health benefit of 20 outpatient visits.

Table 4			
Estimated Prevalence of SUD in Michigan Medicaid and Medicaid Expansion Populations Adults 18 - 64			
	Current Medicaid	Medicaid Expansion	TOTAL
Total Adults	715,204	529,406	1,244,610
Estimated Prevalence of SUD	12.4%	16.9%	
Estimated Number with SUD	88,685	89,470	178,155
Source: SAMHSA National Survey of Drug Use and Health 2008 - 2101 data			

The prevalence of SUDs is expected to be higher in the expansion population (largely uninsured adults) than the current Medicaid population. Of the roughly 530,000 new Medicaid enrollees impacted by expansion in Michigan, SAMHSA projects that nearly 89,000 (16.9%) would have an SUD. (Table 4) The implications of Medicaid expansion on the number of individuals served through CAs is not completely clear. A number of the stakeholders HMA interviewed expressed a belief that the expansion population is already accessing SUD services funded through the CAs’ Community Grant dollars. Others noted that

clients accessing Community Grant services are typically those with very advanced addictions, and that the new coverage populations will have access to SUD diagnosis and treatment through primary care and earlier in their addictions; they might represent an entirely new population seeking SUD diagnosis and treatment.

It is worth noting that Michigan's Medicaid expansion population would include many of the parolees and probationers who today receive SUD treatment authorized by the MDOC and paid for with state general funds. In FY 2012, MDOC paid \$16 million for these services. Under the ACA, between 2014 and 2016 nearly all could be covered by Medicaid (if the beneficiary is enrolled in Medicaid) and funded entirely by federal matching funds (the federal match is 100% for the expansion population until 2016 and no less than 90% thereafter).

In addition, while court-ordered treatment is typically arranged without regard to insurance options, many individuals under court-ordered treatment could be covered by Medicaid or an Exchange plan in 2014 and therefore have access to a SUD service benefit.

Finally, parity could create a significant shift in practice that would align the financial integration of CAs and PIHPs in new way. Managed care cannot stop providing services when its capitation is exhausted, but CAs currently have no resources to continue to cover care once their "budgets" are exhausted. The requirement for parity in SUD service benefits appears to imply that future SUD service benefits may be treated more like a capitated managed care benefit under the PIHPs' budget rather than a fixed CA allocation.

Federal Substance Abuse Block Grant

As of today, the future of SAMHSA block grants for SUD prevention and treatment is completely unknown. Many people presume that since a large volume of today's block grant clients will become Medicaid-eligible, block grants could nearly disappear. Others believe that SAMHSA will continue to fund block grants for the remaining uninsured and focus more dollars on prevention. The future of block grants will affect the demand for SUD treatment in the nation's remaining uninsured, but there are no data to quantify this affect.

The Future Michigan Medicaid SUD Workforce

In Brief

- CAs serving the more rural part of Michigan report difficulty recruiting new direct care staff to provide SUD services.
- CAs and SUD service providers report difficulty retaining SUD staff across all CAs. This is largely attributable to the comparatively low salaries and benefits available to SUD counselors.
- It is likely that demand for SUD services through CAs will grow if Michigan fully implements the ACA. The magnitude of this growth will be linked to efforts to integrate screening for SUD into primary care practice and possible collaboration with the MDOC to provide SUD services to parolees and probationers.

Will the Demand for Medicaid SUD Services Grow?

Michigan CAs currently serve the Medicaid population and, through Community Grant funds, uninsured adults who will become the Medicaid expansion population. As noted above, prevalence of SUDs in the expansion population is greater than in current Medicaid. Table 5 illustrates that Michigan CAs currently serve just over 36% of the population expected to have an SUD. Obviously, not every person with an SUD seeks treatment.

Table 5 Michigan CA Penetration Rate in Medicaid and Expansion Population	
Estimated Number with SUD*	178,155
Total unduplicated clients served by CAs FY 2011	64,768
Calculated Penetration Rate	36.4%
*See Table 4	

Review of admissions data and interviews with CAs and SUD service providers reveal that a high percentage of people accessing SUD services through a CA are doing so because their addiction has become unmanageable or because they must address criminal liability in some fashion. In general, people resist recognizing their own SUDs and often do not seek treatment until they face a crisis like an arrest, a job loss, a divorce, or a health issue. This suggests that the number of individuals served through a CA may not be as sensitive to Medicaid expansion as one would at first suspect.

Medicaid expansion could shift most individuals receiving services paid by Community Grant dollars to Medicaid. This conclusion is supported by a review of income statistics associated with the population served through CAs: in 2011, over 80% of the individuals served through the CAs had income of \$10,000 or below, and fewer than 2.5% reported income of \$30,000 or above. This suggests that most individuals served through CA Community Grant funds will become income eligible for Medicaid in 2014.

HMA sees two factors that could increase the demand for Medicaid SUD treatment. First, availability of a benefit for SUD diagnosis and treatment where none was previously available will likely induce the expansion population to seek services. Note, though, that those whose SUD has progressed to the point of emergency are probably already CA clients.

Primary Care and SUD

In a recent SBIRT pilot project conducted by Genesee County's CA, 17% of primary care patients needed brief intervention for SUD. Of them, 19% (3% of all patients) needed brief intervention and 11% (2% of all patients) needed referral to an SUD service provider.

More importantly, if the expansion population accesses primary care and primary care providers are aware of the SUD service benefits and are comfortable screening and referring to SUD treatment, many more people could be referred for SUD treatment, and at an earlier point in the disease.

Health care professionals are often under-trained and reluctant to assess, address, and treat SUD; the training requirements of most health care professions do not include any mandatory course work in SUDs/addictions. As a result, SUDs is largely unrecognized and undiagnosed in the primary care setting. In FY 2011, just 3% of CA clients were referred into SUD treatment by the medical system. Measures to equip primary care providers with tools and strategies (such as SBIRT) to address SUDs have the potential to vastly improve early detection and intervention for SUDs.¹⁵ To the extent that primary care practitioners become adept at and willing to screen and refer for SUD treatment early in the disease process, the demand for a larger credentialed workforce could range from moderate to dramatic. Table 6 shows that if all the Medicaid expansion populations were exposed to SBIRT through primary care, more than 10,000 of them would be referred to an SUD counselor through a CA. This would expand the CA population by 16%.¹⁶

Table 6 Estimating the Effect of SBIRT on CA Clients	
Medicaid Expansion Population	529,406
2% referral to SUD counselor	10,588
Current CA population	64,768
Increase	16%

Is the Capacity of Today's IC&RC Credentialed SUD Counselors Sufficient?

It is unclear how all the certain and possible changes in the SUD service environment will affect the ability to recruit and retain a sufficient credentialed workforce. The outcome will depend on a number of variables. Several are addressed here.

Michigan CAs do not officially collect and report the capacity of their contracted providers. CAs do not know how many additional clients could be served by their contracted providers. The people we interviewed in urban/suburban CAs reported no concern with local provider ability to address increased demand. Compared to rural providers, they reported fewer concerns about being able to recruit credentialed counselors in the future but noted high rates of staff turnover. Rural providers reported growing difficulties recruiting credentialed counselors.

It is unclear how the MDOC and Medicaid will work together, if at all, to integrate MDOC-referred SUD treatment into the Medicaid program. MDOC requires its contractors to employ IC&RC-credentialed counselors, so the net number of credentialed staff would not go up, but MDOC clients would need to receive services through a CA, which would likely move more credentialed counselors into the CA network.

¹⁵ SBIRT (Screening, Brief Intervention, and Referral to Treatment) is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders designed for use in primary care, hospital emergency rooms, and other community settings.

¹⁶ The Medicaid Expansion estimates reported are consistent with the projections released by the Federal Substance Abuse and Mental Health Services Administration. The Fiscal Year 2013-2014 Executive budget assumes Medicaid caseload growth of about 320,000 in 2014 growing to about 470,000 in 2021.

Finally, it is completely unclear what portion of court-ordered SUD treatment might end up provided by an Exchange plan or a CA. A substitution of insurance-covered SUD service benefits for self-pay could extend the amount of treatment a person receives and, in many cases, would move services to licensed agencies and certified counselors. However, an effort to engage the courts in such a strategy would have to be done at the local level and would be complex. Whether courts acknowledge the availability of insurance coverage and modify their practices remains to be seen.

Summary and Recommendations

Summary

HMA has distilled this complex analysis into the following conclusions.

1. There will likely be an increased demand for treatment of primary SUDs as a result of the expansion of Medicaid eligibility and new access to subsidized insurance coverage through Michigan's Health Insurance Exchange.
2. There will likely be an increased demand for treatment of SUD co-occurring with mental illness and/or chronic medical conditions, and the presence of professionals trained in diagnosis and treatment of addictions will likely diminish in numbers and influence on the treatment teams in these settings.
3. Impending changes in the SUD service environment and on-going barriers to master's-level social workers seeking the IC&RC credential and remaining in the credentialed workforce will reduce the number of IC&RC credentialed counselors who are master's-prepared. This will further reduce the pool of potential supervisors and of persons with SUD service expertise on integrated treatment teams.
4. Counselors credentialed in SUD treatment will be increasingly insufficient in Michigan's rural areas and possibly in the state's more populated areas as well.
5. MDCH and BSAAS need measures to monitor these changes and develop policy that addresses emerging concerns.

These scenarios threaten the quality and integrity of the treatment of SUDs in Medicaid, and we have structured recommendations to address them.

Prior Recommendations

SAMHSA, IC&RC, the ATTC Network, and the MDCH have all produced major reports on the needs of the SUD service workforce and recommendations to address these needs. Appendix 4 presents the major recommendations from five major reports spanning 12 years. Themes appearing throughout the reports include the need for:

- National infrastructure to identify and disseminate best practices in education, recruitment, and retention.
- Elevated public awareness of the SUD treatment profession.
- Credentialing of SUD professionals founded on evidence-based practice.
- Integration of addiction and treatment content in training of all health care professions.
- Leadership development in the SUD service field, especially with respect to integration with mental health and primary care.
- Specific and effective strategies to retain the SUD service workforce.
- Targeted recruitment among young professionals with particular emphasis on diversity.

Two major reports released in 2012 also emphasize the opportunity that the ACA presents to bring attention to SUDs and its treatment, and the need for the SUD service field to develop expert capacity in treating co-occurring SUD and mental illness.

Recommendations for Michigan's Future SUD Workforce

Early identification and intervention in SUDs saves money, lives, and families. Michigan is best served by robust workforce that recognizes and intervenes in SUDs early, that interfaces smoothly with primary care and mental health systems and providers, and that is adept at addressing co-occurring disorders. In addition, Michigan needs a full continuum of SUD services to address needs of advanced SUDs, including relapse mitigation, detox, and short-term intensive and long-term interventions. The continuum must be available in urban, suburban, and rural locations and must be recovery-oriented. Finally, Michigan will benefit from a healthcare workforce that recognizes the prevalence of SUDs, understands the evidence-based practices that are available, and is committed to addressing it in all settings.

Develop and Deploy BSAAS Leadership

Implementation of the ACA provides a new opportunity to advance the treatment of SUDs on many fronts. The social and financial value of early diagnosis and treatment of SUD should motivate MDCH to seize the emerging opportunities and to lead processes that address them. To fully leverage this opportunity, MDCH should deploy new resources to ensure internal capacity and leadership through BSAAS. Some leadership efforts should include the Governor's Office as well. The MDCH through BSAAS leadership should:

Build public awareness of the availability of diagnosis and treatment of SUD through Exchange plans and Medicaid.

The MDCH should be involved in developing public service and marketing messages about any Medicaid expansion and access to Exchange plans and about the efficacy and availability of early intervention and treatment.

Advance and support early diagnosis and treatment of SUD in the primary care setting.

BSAAS should take the lead in heavily promoting SBIRT training for primary care providers, through commercial and Medicaid health plans, and in ensuring that SBIRT services are reimbursable by all plans.

Promote Detection and Treatment at Primary Care Sites

Pairing SUD counselors with primary care to provide onsite screening, assessment, and treatment when medically appropriate produces financial savings and promotes better health outcomes. These partnerships expand the amount of SUD treatment that can be provided by creating provider groups that are trained and supported to diagnose and treat SUD. There are numerous SAMHSA-funded opportunities for this type of partnership with Federally Qualified Health Centers (FQHCs), through medical homes, and more. BSAAS should lead statewide efforts to advance and evaluate integration of SUD services into primary care.

Consider Which IC&RC Credentials Are Most Appropriate in the Emerging Environment

Michigan Medicaid is committed to requiring IC&RC certification for SUD counselors, and that commitment has increased the quality of Michigan's SUD services. HMA recommends that BSAAS convene a group of stakeholders to consider whether the IC&RC clinical supervisory credential (which accounts for 11% of those in development plans) provides sufficient return to the quality of care to offset the expense in every situation. It may make sense to limit the requirement for a clinical supervisory credential to certain treatment environments.

BSAAS should also lead a new discussion of how best to assure that all counselors treating clients with co-occurring SUD and mental illness are competent. Currently, PIHPs do not require that counselors treating primary mental illness with secondary SUD have any formal SUD treatment training. It may be wise to revisit the use of a person with IC&RC credentials in co-occurring disorders as part of the treatment team or in a clinical advisory capacity of some sort. The strengthened integration of CAs and PIHPs is an opportunity for this to develop.

BSAAS should also engage stakeholders in meaningful consideration of how best to engage licensed social workers in the SUD treatment continuum and should revisit this as the environment changes over the next decade.

Stakeholders should include SUD service providers, CAs, PIHPs, academic partners, and professional associations.

Partnership with Michigan Department of Corrections

BSAAS should lead discussions with the MDOC to explore means to extend Medicaid SUD service benefits to parolees and probationers, to better integrate the SUD treatment system and draw federal matching funds.

Educate the Judicial System

BSAAS should conduct and organize effort to educate the state's judicial system (including drug courts) about SUD service benefits available as a result of the ACA.

Academic Collaboration to Build SUD Training into All Health Professions

BSAAS should work with Michigan's colleges, universities, community colleges, MCBAP, professional associations, and other stakeholders to ensure that every health professions curriculum includes appropriate training in SUDs and addictions prevalence, pathology, diagnosis, and treatment.

Raise Reimbursement for SUD Services

MDCH and the legislature should recognize that an increase in SUD reimbursement rates targeted to the pay and benefits of direct care staff would effectively mitigate many of the problems in ensuring an adequate workforce as identified in this report. Through a Medicaid expansion, the state can increase payment rates for the new population and receive 100% federal match. The same payment must apply to the current Medicaid population as well, which would increase program expense, but the net effect may be fairly small. Medicaid should carefully consider this strategy.

Recruit New IC&RC Credentialed SUD Workers

The challenges in recruiting IC&RC credentialed workers are significant and require concerted effort to overcome. Michigan should:

- Adopt some of the strategies used by the nursing profession in characterizing, advertising, and correcting nursing shortages. These include developing public and legislative awareness about emerging shortages and streamlining the ability to move through career paths.
- Develop awareness among high school and college students, especially minorities about the SUD service field and how counselors change lives for the better. Promote IC&RC opportunity for development plans. Target specific urban high schools.
- Develop tuition reimbursement and loan forgiveness strategies, especially for shortage areas.
- Conduct research with MCBAP to identify opportunities to target resources to persons in development plans, to ensure completion.
- Update healthcare workforce shortage information on Michigan's LARA Health Careers website.
- Develop a statewide, integrated strategy to connect college, university, and community college health career programs with CAs and SUD service providers for academic rotations, internships, and externships.

Retain Credentialed SUD Counselors

Challenges in retaining IC&RC-credentialed counselors are significant; poor pay and benefits compared to other opportunities, a lack of career ladder opportunities, and professional burnout are endemic. BSAAS should challenge PIHPs and CAs to develop full-time employment opportunities for SUD counselors that include benefits, subsidies for continuing education requirements, and career development options. Extending the capacity of IC&RC-credentialed counselors, discussed below, could also serve as an important element in employee retention.

Extend the Capacity of Credentialed SUD Counselors

As noted, credentialed SUD counselors are in short supply in Michigan's rural communities. If the demand for SUD treatment grows with Medicaid expansion, the supply could be strained in other communities too. Michigan should adopt measures to extend the capacity of the SUD service workforce for rural areas immediately and also be prepared to use the measures where other shortages emerge. All of the following would "stretch" the ability of the current credentialed workforce to serve more clients.

- Use telehealth to deploy SUD counselors from well-staffed locales to rural areas. "Telehealth" includes traditional telemedicine via videoconferencing, using Skype and other public domain software, and even telephone and texting as an adjunct to other encounters.
- Explore the use of an IC&RC-credentialed counselor as advisory to another non-credentialed counselor. This could work especially well where the non-credentialed counselor is a licensed social worker.
- Explore the use of an IC&RC-credentialed counselor as a member of or advisor to the larger treatment team.

Monitor Changes in the Field

Michigan's plan to merge CAs into PIHPs affords a new opportunity to better address SUD co-occurring with mental illness and to develop models for the most efficient use of IC&RC credentialed counselors and supervisors, peer-support personnel, and mental health practitioners in a team approach. HMA believes that much of this could occur "under the radar" in ways that are not readily observable or measureable under current reporting requirements. BSAAS should pro-actively establish a "surveillance model" of specific measures before this change is implemented. Measures should carefully monitor changes in the portion of clients deemed primary SUD and those with co-occurring mental illness, who is providing their SUD treatment, and the credentials of the treatment team members.

BSAAS should also require CAs to establish and report on the capacity of their provider networks to accept additional clients by type of service.

The state should require MCBAP to collect more complete data on the demographics of its counselors, credentialed and in development plans, and to provide regular reports on selected measures to MDCH.

BSAAS should analyze these data and emerging changes in the field, and lead efforts to address emerging concerns.

Attachments

Attachment 1: Individuals and Organizations Interviewed

Michigan Substance Use Disorder Workforce Review: Interview Subjects		
NAME	ORGANIZATION	CATEGORY
Kristie Schmiede	Michigan Association of Substance Abuse Coordinating Agencies Genesee County Community Mental Health Board Member, MCBAP	Trade Association CA (CMH), Certification Board
Michael Vizena	Michigan Association of Community Mental Health Boards	Trade Association
Robin Reynolds	Ingham Health Plan (formerly with Mid South Substance Abuse Commission)	CA (Stand Alone) General Expertise
Karen Youngs Hartley	Michigan Certification Board of Addiction Professionals	Certification Board
Christina Nicholas Sherri Kilpatrick	Oakland County Health Division-Office of Substance Abuse Services	CA (Local Public Health)
Mark Halkola	Western Upper Peninsula Substance Abuse Services Coordinating Agency	CA (Stand Alone/Rural)
Ruth Sebaly Darlene Owens Theresa Webster	Southeast Michigan Community Alliance	CA (Stand Alone/Urban)
Grady Wilkinson	Provider Alliance: Sacred Heart Center	Provider
Bret Finzel	Provider Alliance: Sunrise Center	Provider
Mike Reagan	Provider Alliance: Cherry Street Health Services	Provider
Monique Stanton	Provider Alliance: CARE of Southeastern Michigan	Provider
Terry Newton	Provider Alliance: Harbor Health	Provider
Sam Price	Provider Alliance: 1016 Recovery Network	Provider
Maxine Thome	National Association of Social Workers-Michigan Chapter	Trade Association
Bruce Thomson	National Association of Social Workers-Michigan Chapter	Provider
Sandy Carnes	Stanford House	Consumer

Attachment 2: County Definitions Used By HMA

HMA's review of provider access in urban and rural markets was used using county level provider data. HMA defined rural counties as any county designated as rural by the Federal Department of Health and Human Services, Office of Rural Health Policy. The Office of Rural Health Policy identifies all counties not that are not, in whole or in part, part of a Metropolitan Area as defined by the Federal Office of Management and Budget.

COUNTY	DESIGNATION	COUNTY	DESIGNATION	COUNTY	DESIGNATION
Alcona	Rural	Huron	Rural	Oakland	Non-Rural
Alger	Rural	Ingham	Non-Rural	Oceana	Rural
Allegan	Rural	Ionia	Non-Rural	Ogemaw	Rural
Alpena	Rural	Iosco	Rural	Ontonagon	Rural
Antrim	Rural	Iron	Rural	Osceola	Rural
Baraga	Rural	Isabella	Rural	Oscoda	Rural
Barry	Rural	Jackson	Non-Rural	Otsego	Rural
Bay	Non-Rural	Kalamazoo	Non-Rural	Ottawa	Non-Rural
Benzie	Non-Rural	Kalkaska	Rural	Presque Isle	Rural
Berrien	Rural	Kent	Non-Rural	Roscommon	Rural
Branch	Non-Rural	Keweenaw	Rural	Saginaw	Non-Rural
Calhoun	Rural	Lake	Rural	Sanilac	Rural
Cass	Non-Rural	Lapeer	Non-Rural	Schoolcraft	Rural
Charlevoix	Non-Rural	Leelanau	Rural	Shiawassee	Rural
Cheboygan	Rural	Lenawee	Rural	St. Clair	Non-Rural
Chippewa	Rural	Livingston	Non-Rural	St. Joseph	Rural
City of Detroit	Rural	Luce	Rural	Tuscola	Rural
Clare	Non-Rural	Mackinac	Rural	Van Buren	Non-Rural
Clinton	Rural	Macomb	Non-Rural	Washtenaw	Non-Rural
Crawford	Non-Rural	Manistee	Rural	Wayne	Non-Rural
Delta	Rural	Marquette	Rural	Wexford	Rural
Dickinson	Rural	Mason	Rural		
Eaton	Non-Rural	Mecosta	Rural		
Emmet	Rural	Menominee	Rural		
Genesee	Non-Rural	Midland	Rural		
Gladwin	Rural	Missaukee	Rural		
Gogebic	Rural	Monroe	Non-Rural		
Grand Traverse	Rural	Montcalm	Rural		
Gratiot	Rural	Montmorency	Rural		
Hillsdale	Rural	Muskegon	Non-Rural		
Houghton	Rural	Newaygo	Non-Rural		

Attachment 3: SUD Providers Contracted by Both Coordinating Agencies and Michigan Department of Corrections

OUTPATIENT SUD SERVICE CONTRACTORS:

MI DEPT OF CORRECTIONS AND MICHIGAN COORDINATING AGENCIES

There are 25 providers of OP services that MDOC contracts with and who are NOT under contract to Coordinating Agencies.

There are an additional 4 providers that MDOC contracts with for OP services and CAs contacts with them for servicers other than OP. (Highlighted pink)

There are 44 providers of OP services serving both MDOC and CAs.

Dept. of Corrections Provider	MDOC County	MDOC Service	CA-Contracted Provider?	CA Service	CA County
Apex	Wayne	OP	NO		
Apex	Macomb	OP	NO		
Catholic Social Services of Wayne	Wayne	OP	NO		
ETRS-Berkley	Wayne	OP	NO		
ETRS-Berkley	Oakland	OP	NO		
ETRS-Taylor	Wayne	OP	NO		
ETRS-Taylor	Oakland	OP	NO		
St. Vincent Catholic Charities	Clinton	OP	NO		
St. Vincent Catholic Charities	Eaton	OP	NO		
St. Vincent Catholic Charities	Ingham	OP	NO		
Catholic Charities of Jackson, Lenawee & Hillsdale	Jackson	OP	NO		
Catholic Charities of Jackson, Lenawee & Hillsdale	Lenawee	OP	NO		
Complete Counseling Center, Inc.	Livingston	OP	NO		
Nexus Family Services	Antrim	OP	NO		
Nexus Family Services	Grand Traverse	OP	NO		
Nexus Family Services	Kalkaska	OP	NO		
Nexus Family Services	Leelanau	OP	NO		
Nexus Family Services	Missaukee	OP	NO		
Nexus Family Services	Wexford	OP	NO		
Partners in Change	Isabella	OP	NO		
Partners in Change	Midland	OP	NO		
WMU Behavioral Health Services	Calhoun	OP	NO		
WMU Behavioral Health Services	Kalamazoo	OP	NO		
WMU Behavioral Health Services	St. Joseph	OP	NO		
WMU Behavioral Health Services	Van Buren	OP	NO		
CareFirst	Wayne	OP	YES	IOP	Detroit
Catholic Social Services of Washtenaw	Washtenaw	OP	YES	Prevention	Washtenaw

Dept. of Corrections Provider	MDOC County	MDOC Service	CA-Contracted Provider?	CA Service	CA County
Community Programs, Inc.	Oakland	OP	YES	Detox / Res	Macomb, Oakland, St. Clair
Community Programs, Inc.	Wayne	OP	YES	Detox / Res	Macomb, Oakland, St. Clair
Quality Behavioral Health	Wayne	OP	YES	O/M/R	Detroit, Macomb
Salvation Army Harbor Light-Detroit	Wayne	OP	YES	OP	Wayne
Salvation Army Harbor Light-Macomb	Macomb	OP	YES	OP	Macomb
Self Help Addiction (SHAR)	Macomb	OP	YES	OP/Detox/Res	Macomb
Self Help Addiction (SHAR)	Wayne	OP	YES	OP/Detox/Res	Detroit
Woodward Counseling Inc.	Oakland	OP	YES	IOP	Genesee, Oakland
Catholic Charities of West MI	Allegan	OP	YES	OP	Kalamazoo, Ottawa, Muskegon, Mecosta, Mason
Catholic Charities of Shiawassee & Genesee	Bay	OP	YES	OP	Bay, Genesee,
Catholic Charities of West MI	Kent	OP	YES	OP	Kent
Catholic Charities of Shiawassee & Genesee	Genesee	OP	YES	OP	Genesee
Catholic Charities of Shiawassee & Genesee	Lapeer	OP	YES	OP	Lapeer
Catholic Charities of West MI	Lake	OP	YES	OP	Lake
Catholic Charities of Livingston County	Livingston	OP	YES	Prevention	Washtenaw
Catholic Social Services of Washtenaw	Monroe	OP	YES	OP	Monroe
Catholic Charities of West MI	Muskegon	OP	YES	OP	Muskegon
Catholic Charities of West MI	Ottawa	OP	YES	OP	Ottawa
Catholic Charities of Shiawassee & Genesee	Saginaw	OP	YES	OP	Saginaw
Catholic Charities of Shiawassee & Genesee	Shiawassee	OP	YES	OP	Shiawassee
Catholic Social Services of St. Clair County	St. Clair	OP	YES	IOP	St. Claire
G.R.A.C.E Center	Crawford	OP	YES	OP	Northern
G.R.A.C.E Center	Roscommon	OP	YES	OP	Roscommon
Great Lakes Recovery Centers	Alger	OP	YES	Residential , IOP	Northern, Pathways
Great Lakes Recovery Centers	Chippewa	OP	YES	OP	Chippewa

Dept. of Corrections Provider	MDOC County	MDOC Service	CA-Contracted Provider?	CA Service	CA County
Great Lakes Recovery Centers	Delta	OP	YES	OP	Delta
Great Lakes Recovery Centers	Dickinson	OP	YES	OP	Dickinson
Great Lakes Recovery Centers	Gogebic	OP	YES	OP	Gogebic
Great Lakes Recovery Centers	Luce	OP	YES	OP	Luce
Great Lakes Recovery Centers	Mackinac	OP	YES	OP	Mackinac
Great Lakes Recovery Centers	Marquette	OP	YES	OP	Marquette
Great Lakes Recovery Centers	Schoolcraft	OP	YES	OP	Schoolcraft
KPEP	Berrien	OP	YES	OP	Lakeshore
KPEP	Calhoun	OP	YES	OP	Calhoun
KPEP	Cass	OP	YES	OP	Cass
KPEP	Kalamazoo	OP	YES	OP	Kalamazoo
KPEP	Muskegon	OP	YES	OP	Muskegon
New Light Consultants	Tuscola	OP	YES	OP	Wayne, Bay, Arenac,
New Paths, Inc.	Genesee	OP	YES	OP	Genesee
North Kent Guidance	Kent	OP	YES	OP	Bay, Arenac,
North Kent Guidance	Montcalm	OP	YES	OP	Montcalm
Pine Rest Christian	Kent	OP	YES	OP, Res	Bay, Arenac, Kalamazoo, Kent
Saginaw Psychological Services, Inc.	Bay	OP	YES	OP	Saginaw
Saginaw Psychological Services, Inc.	Saginaw	OP	YES	OP	Saginaw
Salvation Army Harbour Light	Monroe	OP	YES	OP	Monroe
Woodward Counseling Inc.	Genesee	OP	YES	OP	Genesee

**RESIDENTIAL SUD SERVICE CONTRACTORS:
MI DEPT OF CORRECTIONS AND MICHIGAN COORDINATING AGENCIES**

MDOC contracts with 35 providers for residential services.

Coordinating Agencies contracts with 28 of the same providers for residential services, and with another three for other services. (Highlighted pink)

Dept. of Corrections Provider	MDOC County	MDOC Service	CA-Contracted Provider?	CA Service	CA County
Heartline Inc. / Lutheran SS of MI	Wayne	RES	NO	Residential	Wayne
Vision House	Wayne	RES	NO	Residential	Wayne
Alternative Directions	Kent	RES	NO	Residential	Kent
West Michigan Therapy	Muskegon	RES	NO	Residential	Muskegon
Community Programs, Inc.	Oakland	RES	YES	Residential	Oakland
Elmhurst Home, Inc.	Wayne	RES	YES	Residential	Wayne
Salvation Army Harbor Light-Detroit	Wayne	RES	YES	Residential	Wayne
Salvation Army Harbor Light-Macomb	Macomb	RES	YES	Residential	Macomb
Self Help Addiction (SHAR)	Wayne	RES	YES	Residential	Wayne
Self Help Addiction (SHAR)	Macomb	RES	YES	Residential	Macomb
Sobriety House	Wayne	RES	YES	OP, Residential	Detroit
Addiction Treatment Services (ATS)	Grand Traverse	RES	YES	OP	Detroit
CEI Community Mental Health-House of Commons	Clinton	RES	YES	OP, Residential	Bay, Arenac
CEI Community Mental Health-House of Commons	Eaton	RES	YES	Residential	Eaton
CEI Community Mental Health-House of Commons	Ingham	RES	YES	Residential	Ingham
Cherry Street Services, Inc.	Kent	RES	YES	OP/Methadone	Lakeshore
Great Lakes Recovery Center-New Hope House for Men	Chippewa	RES	YES	Residential, Detox	Pathways, Western UP
Great Lakes Recovery Center-New Hope House for Women	Chippewa	RES	YES	Residential	Chippewa
Great Lakes Recovery Center	Marquette	RES	YES	Residential	Marquette
Harbor Hall	Emmet	RES	YES	OP/Detox/Res	Northern
KPEP	Berrien	RES	YES	Residential	Berrien
KPEP	Calhoun	RES	YES	Residential	Calhoun
KPEP	Kalamazoo	RES	YES	Residential	Kalamazoo
KPEP	Muskegon	RES	YES	Residential	Muskegon
New Paths, Inc.	Genesee	RES	YES	Residential	Genesee
Ottogan Addiction Recovery, Inc. Chester A. Ray	Allegan	RES	YES	Residential	Kalamazoo, Lakeshore
Ottogan Addiction Recovery, Inc. Chester A.	Muskegon	RES	YES	Residential	Muskegon

Dept. of Corrections Provider	MDOC County	MDOC Service	CA-Contracted Provider?	CA Service	CA County
Ray					
Ottogan Addiction Recovery, Inc. Chester A. Ray	Ottawa	RES	YES	Residential	Ottawa
Ottogan Addiction Recovery, Inc. Harbor House	Allegan	RES	YES	Residential	Kalamazoo
Ottogan Addiction Recovery, Inc. Harbor House	Muskegon	RES	YES	Residential	Muskegon
Ottogan Addiction Recovery, Inc. Harbor House	Ottawa	RES	YES	Residential	Ottawa
Pine Rest Jellema Treatment Center	Kent	RES	YES	Residential	Kent
Saginaw Psychological Services, Inc.	Saginaw	RES	YES	Residential	Saginaw
Salvation Army Harbor Light - Monroe	Monroe	RES	YES	Residential	Monroe
Sunrise Center	Alpena	RES	YES	OP	Northern

Attachment 4: Summary of Recommendations Federal and State SUD Workforce Analysis 2006-2012

Substance Abuse and Mental Health Services Administration Report to Congress Addictions Treatment Workforce Development: <i>Substance Abuse and Mental Health Services Administration, 2006</i>	
Infrastructure Development	<ul style="list-style-type: none"> • Create career paths for the treatment and recovery workforce and adopt national core competency standards. • Foster network development. • Provide technical assistance to enhance the capacity to use information technology.
Leadership and Management	<ul style="list-style-type: none"> • Develop, deliver, and sustain training for treatment and recovery support supervisors, who serve as the technology transfer agents for the latest research and best practices. • Develop, deliver, and sustain leadership and management development initiatives.
Recruitment	<ul style="list-style-type: none"> • Expand recruitment of health care professionals in addictions medicine. • Improve student recruitment with educational institutions, focusing on under-represented groups. • Employ marketing strategies to attract workers to the addictions treatment field. • Continue efforts to reduce the stigma associated with working in addictions treatment.
Addictions Education and Accreditation	<ul style="list-style-type: none"> • Include training on addictions as part of education programs for primary health care and for other health and human service professions (e.g., physicians, nurses, psychologists, and social workers). • Call for the use of national addictions core competencies as the basis of curricula. • Support the development and adoption of national accreditation standards for addictions education programs. • Encourage national and state boards for the health professions to have at least 10 percent of licensing examination questions pertain to addictions. • Support academic programs in Historically Black Colleges and Universities (HBCUs), Hispanic Serving Institutions, Tribal Colleges and Universities, and other minority-serving institutions. • Develop college and university courses on health services research and its application; and systematically disseminate research findings to academic institutions.
Retention	<ul style="list-style-type: none"> • Identify and disseminate best practices in staff retention. • Address substance misuse and relapse within the workforce.
Study	<ul style="list-style-type: none"> • Conduct studies that examine the relationships among level of education, type of education, training, and treatment outcomes. • Conduct studies that examine the relationships among clinician and patient/client, cultural, demographic and other characteristics, therapeutic alliance and treatment outcomes. • Conduct studies that explore questions related to the characteristics of clinicians' training and skills that enhance therapeutic alliance.

Department of Community Health Workforce Development Workgroup Final Report: Office of Drug Control Policy¹⁷, October 2006

ODCP/MDCH endorse the IC&RC credentialing requirements specific to substance abuse prevention and treatment including the Certified Criminal Justice Professional (CCJP) credential. However, that other recognized credentials comparable and equivalent to the Certified Addiction Counselor (CAC), Certified Clinical Supervisor (CCS), Certified Prevention Specialist (CPS) and/or Certified Prevention Consultant (CPC) be considered as acceptable in lieu of these IC&RC credentials. For example, recognition that the Certified Health Education Specialist (CHES) credential demonstrates competence in core prevention skills or state licensed professionals along with their national association having a specialty in addiction.

The credentialing requirement applies to those individuals who provide clinical services, prevention programs, and supervisors/managers. Staff whose job responsibilities are paraprofessional or specially focused in nature, such as, for example, residential aides, prevention staff whose responsibilities are specific to the application of specific practices, or generalist case managers would not require credentialing when these staff work under the supervision of credentialed staff.

That Michigan specific grand parenting provisions as well as IC&RC reciprocal grand parenting provisions be adopted.

That provision for cost implications to the provider network for access to credentialed staff, supervisory requirements and training/continuing education requirements on billable service time are considered in the rate setting process.

That a sufficient but prompt period of time be provided for individuals, providers and CAs to implement credentialing requirements.

That training or other support be made available for staff to meet credentialing requirements with recognition to diversity and geographic availability. Further, that long range, relationships with universities for development of addiction-specific curriculum be developed.

An Action Plan for Behavioral Health Workforce Development: Substance Abuse and Mental Health Services Administration (SAMHSA), 2007

Significantly expand the role of individuals in recovery, and their families when appropriate, to participate in, ultimately direct, or accept responsibility for their own care; provide care and supports to others; and educate the workforce.

- Provide information and education to individuals in care or recovery and their families to enable them to fully participate in or direct their own care and to assist and support each other.
- Develop shared decision-making skills among individuals receiving care and their families and service providers.
- Significantly expand peer and family-support services and routinely offer them in systems of care.
- Increase the employment of individuals in recovery and family members as paid staff in provider organizations.
- Formally engage persons in recovery and family members in substantive roles as educators for other members of the workforce in every provider training and education program.

Expand the role and capacity of communities to effectively identify their needs and promote behavioral health and wellness.

- Support communities in their development of the core competencies of assessment, capacity building, planning, implementation, and evaluation.
- Increase the competency of the behavioral health workforce to build community capacity and collaborate with communities in strengthening the behavioral health system of care.
- Strengthen existing connections between behavioral health organizations and their local communities.

¹⁷ Current Michigan Department of Community Health Bureau of Substance Abuse and Addiction Services (BSAAS)

An Action Plan for Behavioral Health Workforce Development: Substance Abuse and Mental Health Services Administration (SAMHSA), 2007

Implement systematic recruitment and retention strategies at the federal, state, and local levels.

- Disseminate information and technical assistance in effective recruitment and retention strategies.
- Select, implement, and evaluate recruitment and retention strategies tailored to the unique needs of each behavioral health organization.
- Expand federal financial incentives, such as training stipends, tuition assistance, and loan forgiveness, to increase recruitment and retention.
- Provide wages and benefits commensurate with education, experience, and levels of responsibility.
- Implement a comprehensive public relations campaign to promote behavioral health as a career choice.
- Develop career ladders.
- Expand the use of “grow-your-own” recruitment and retention strategies focused on residents of rural areas, culturally diverse populations, and consumers and families.
- Increase the cultural and linguistic competence of the behavioral health workforce.

Increase the relevance, effectiveness, and accessibility of training and education.

- Identify core competencies and focused competencies for behavioral health practice.
- Develop and implement competency-based curricula.
- Adopt evidence-based training methods that have been demonstrated as effective through research.
- Use technology to increase access to and the effectiveness of training and education.
- Launch a national initiative to ensure that every member of the behavioral health workforce develops basic competencies in the assessment and treatment of substance use disorders, and co-occurring mental and addictive disorders.
- Educate prospective students about best practices in training and education to inform their selection of a training program or training provider.
- Identify and implement strategies to support and sustain the use of newly acquired skills in practice settings.

Actively foster leadership development among all segments of the workforce.

- Identify leadership competencies tailored to the unique challenges of behavioral health care.
- Identify effective leadership curricula and programs and develop new training resources to address existing gaps.
- Increase support for formal continuous leadership development with current and emerging leaders in all segments of the workforce.
- Formally evaluate leadership development programs based on defined criteria and revise the programs based on outcomes.

Enhance the infrastructure available to support and coordinate workforce development efforts.

- Create a National Technical Assistance Structure that coordinates and provides information, guidance, and support on workforce development to the behavioral health field and advises the federal government.
- Create a federal Behavioral Health Workforce Partnership, led by a SAMHSA Workforce Team.
- Finance workforce demonstrations through a National Workforce Development Fund and foundation-sponsored initiatives.
- Change the economic market for services to create conditions that improve the quality of care and strengthen the workforce.
- Increase the use of data to track, evaluate, and manage key workforce issues.
- Strengthen the human resources and training functions, staffing, and levels of expertise in behavioral health organizations.
- Promote the increased availability and use of information technology to support the workforce during training and service delivery.
- Identify Magnet Centers in workforce best practices, drawing on the “Magnet Hospital” concept from the field of nursing.

An Action Plan for Behavioral Health Workforce Development: Substance Abuse and Mental Health Services Administration (SAMHSA), 2007

Implement a national research and evaluation agenda on behavioral health workforce development.

- Increase the quantity and quality of workforce-related research through creation of a federal interagency research collaborative.
- Increase the quantity and quality of formal evaluations of workforce development practices by providing technical assistance to the field.

VITAL SIGNS: Taking the Pulse of the Addiction Treatment Profession: Substance Abuse and Mental Health Services Administration, September 28, 2012

SUD treatment facilities should consider recruiting professional or pre-professional individuals in their 20s and 30s from diverse backgrounds to the workforce. Federal and state policymakers and other stakeholder groups should support programs that promote the SUD treatment field as a career choice for young graduates. SUD treatment facilities should consider establishing relationships with colleges and universities in order to recruit new staff members. They should also continue to draw from the recovery community in their recruitment efforts.

SUD treatment practitioners should continue to earn degrees in higher education as well as professional credentials.

SUD treatment practitioners should also increase their technological competency. Educational opportunities related to building the computer and web-based technology skills of SUD treatment practitioners should be made available to facilities at low or no cost. Also, pre-service educational programs for SUD treatment practitioners should include training on computer and web-based technology skills, including the use of EHR systems.

SUD treatment practitioners should become familiar with online learning, including how to navigate e-learning software and how to get the most out of web-based courses.

SUD treatment facilities should adopt a collaborative learning culture and support staff members in their ongoing education, providing financial support if possible.

Federal and state policy makers should continue to support programs, such as the ATTC Network, that provide low or no cost training opportunities, including online training.

To save on training costs, SUD treatment facilities should consider sending qualified staff to “training of trainers” events, such as those often offered through the ATTC Network, so that they can develop internal capacity to provide training.

SUD treatment facilities should consider increasing efforts to retain direct care staff.

Leadership training, including how to develop and lead positive teams, should be made available to executive and clinical directors of SUD treatment facilities.

Management training, including how to provide constructive feedback and how to establish a positive work environment, should be made available for administrators and managers of SUD treatment facilities.

SUD treatment facility directors should investigate strategies that have been shown to help employees achieve a healthy work/life balance and should consider implementing such benefits as appropriate in their organizations.

SUD treatment facilities should provide regular, ongoing support for clinical supervision.

Since 60% of clinical directors are over age 50, focused efforts to develop individuals who can replace existing clinical directors in their leadership positions should be a priority for the SUD treatment field.

Clinical directors should consider integrating observation methods such as role-play and tape review into their work.

Policymakers and other stakeholders should continue to work to educate SUD treatment facilities about the impact healthcare reform will have on the way they do business. These activities should include efforts to build relationships between specialty SUD treatment facilities and primary care organizations. Also, SUD treatment providers should consider gaining an understanding of the culture of primary care and how best to work in integrated healthcare environments.

As healthcare reform changes the reimbursement structure for SUD treatment services, advocates for the field should consider mounting a concerted effort to ensure that SUD treatment practitioners are reimbursed on an equal level with other healthcare professionals.

VITAL SIGNS: Taking the Pulse of the Addiction Treatment Profession: *Substance Abuse and Mental Health Services Administration*, September 28, 2012

SUD treatment facilities need to better understand EBP implementation models. Training alone is never enough. Facilities need to support the breadth and depth of changes that need to occur to ensure successful EBP implementation efforts.

The SUD treatment field should continue to develop a shared understanding of the components of a recovery-oriented system of care. Localities should consider identifying facilitators that can help guide systems toward a recovery orientation. Stakeholders at all levels need to maintain an unwavering commitment to recovery-oriented care.

Members of the SUD treatment workforce should become strong advocates for the recognition of SUDs as a valid healthcare issue. The health of the nation will depend on a greater understanding of the ways in which SUDs complicate, if not cause, other health issues such as heart disease. The roll out of the ACA offers a unique opportunity for screening and treatment for SUDs to become a regular part of healthcare.

SUD treatment facilities must adopt and implement EHR systems in order to survive. Current and future SUD treatment practitioners need to have the skills to operate EHR systems in order to continue working in healthcare. Federal and state policymakers should consider supporting programs that assist SUD treatment facilities to utilize HIT.

Integrated Treatment for Co-Occurring Substance Use and Mental Health Disorder, The Future of Our Workforce Is Now: *International Certification and Reciprocity Consortium (IC&RC)*, November, 2012

Simply adopting new standards does not create the infrastructure to meet those standards. Truly embracing COD standards requires the behemoths of certification boards, higher education, licensing boards and even insurance panels—separate entities that generally co-exist—to reduce silo thinking in favor of cooperation and communication. In order to develop the next generation of a skilled workforce and increase capacity in the COD profession, the key constituents in the preparation and credentialing process need to operate in some degree of alignment. With this new incentive of international COD credentialing standards, a collective response will best answer the call for increased relevance, effectiveness and accessibility of education opportunities (SAMHSA, 2007) for a well-prepared workforce.

Currently, continuing education for all segments of the workforce tends to rely on single-session, didactic approaches which have proven ineffective in changing workforce practice patterns (SAMHSA, 2007). We anticipate that it will become desirable to have a comprehensive and cohesive accumulation of well-designed academic courses to submit as evidence of the necessary contact hours of COD specific coursework, rather than an accumulation of assorted certificates that document attendance in an array of workshop.

Higher education programs can bridge many of these disjointed processes by remaining more responsive to trends in the field and implementing well-informed curriculum changes that stay abreast of workforce realities. It no longer suffices that ivory tower thinking will provide adequate training. Health care reform in the United States, whatever its final form, will undoubtedly push for the elimination of duplicative services and services that are not evidence-based. With this reality, counselor education must keep up the pace with best practice designed for co-occurring disorders.

Recommended Action	An Action Plan for Behavioral Health Workforce Development	Integrated Treatment for Co-Occurring Substance Use and Mental Health Disorder	SAHMSA Report to Congress Addictions Treatment Workforce Development	Vital Signs: Taking the Pulse of Addiction Treatment Profession	MDCH Workforce Development Workgroup Final Report
Public Sector Technical Assistance to Providers in Recruitment/Retention					
Provide Financial Support for Provider Training / Education					
Take Steps to Improve Reimbursement, Wages and Benefits					
Market Profession to Possible Providers					
Establish Career Ladders within SUD Service Agencies					
Steps to Improve Cultural / Linguistic Diversity of Providers					
Improve Academic Curriculum Related to SUD Treatment					
Establish Partnerships with Colleges / Universities					
Improve Training Available to SUD Service Providers					
Use Technology to Improve Access to Training					
Improve Leadership Development within SUD Service Workforce					
Integrate SUD Service Training into Other Health Education Efforts					
Utilize "Train the Trainer" Strategies					
Focus on Quality of Life (work/life balance) Improvements to Retain Staff					

Attachment 5: Treatment Provider Requirements by Payer and Patient Type

This table illustrates that SUD service payment sources, payers, and Michigan courts use differing criteria in establishing the criteria for SUD counselors.

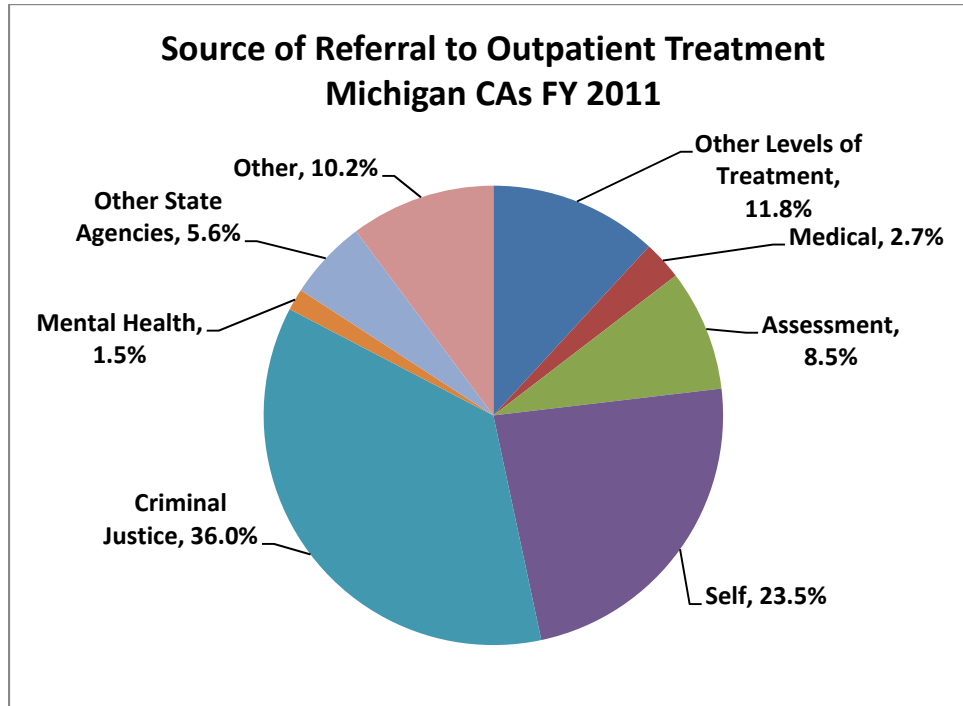
It also shows that a person with an SUD may receive SUD treatment from differently credentialed counselors, depending on whether the SUD is primary, or secondary to a mental illness.

TREATMENT PROVIDER REQUIREMENTS BY PAYER AND PATIENT TYPE	No College Degree		Bachelors Social Work		Master's Social Work			
					Licensed			
	Plan for Certification		Plan for Certification		No		Yes	
	No	Yes	No	Yes	No	Yes	No	Yes
Commercial insurance								
SUD primary			X	X	X	X	X	X
Mental health primary			X	X	X	X	X	X
Medicaid								
SUD primary		X		X		X		X
Mental health primary						X		X
Community Grant								
SUD primary		X		X		X		X
Mental health primary						X		X
Court ordered								
SUD primary	X	X	X	X	X	X	X	X
Corrections								
SUD primary		X		X		X	X	X

Attachment 6: Source of Referral to Outpatient Treatment: Michigan CAs FY 2011

This figure reflects, for Michigan CA clients entering outpatient retreatment, the referral source for that treatment.

Note that only 3% of CA clients entering outpatient treatment were referred through the medical system, which would include primary care and emergency room providers.



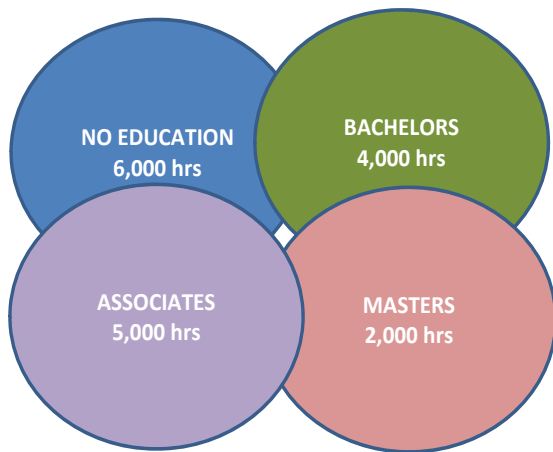
Attachment 7: IC&RC Certification Requirements

This Figure illustrates the training requirements for various persons seeking the IC&RC credential for Certified Alcohol and Drug Counselor.

All certifications recognized by MCBAP are listed as well.

IC & RC CERTIFICATION REQUIREMENTS AND CREDENTIALS

Certified Alcohol and Drug Counselor (CADC)
2,000 - 6,000 hours full or part-time work
270 contact hours of education
300 hours supervised practical training
Applicants have three years to complete a development plan



Credentials Offered by MCBAP

IC-RC RECIPROCAL

Certified Advanced Alcohol and Drug Counselor (**CAADC**)
 Certified Alcohol and Drug Counselor (**CADC**)
 Certified Clinical Supervisor (**CCS**)
 Certified Co-Occurring Disorders Professional (**CCDP**)
 Certified Co-Occurring Disorders Professional-Diplomat (**CCDP-D**)
 Certified Advanced Alcohol and Drug Counselor (**CAADC**)
 Certified Prevention Specialist (**CPS/CPC-R**)
 Certified Criminal Justice Professional (**CCJP**)

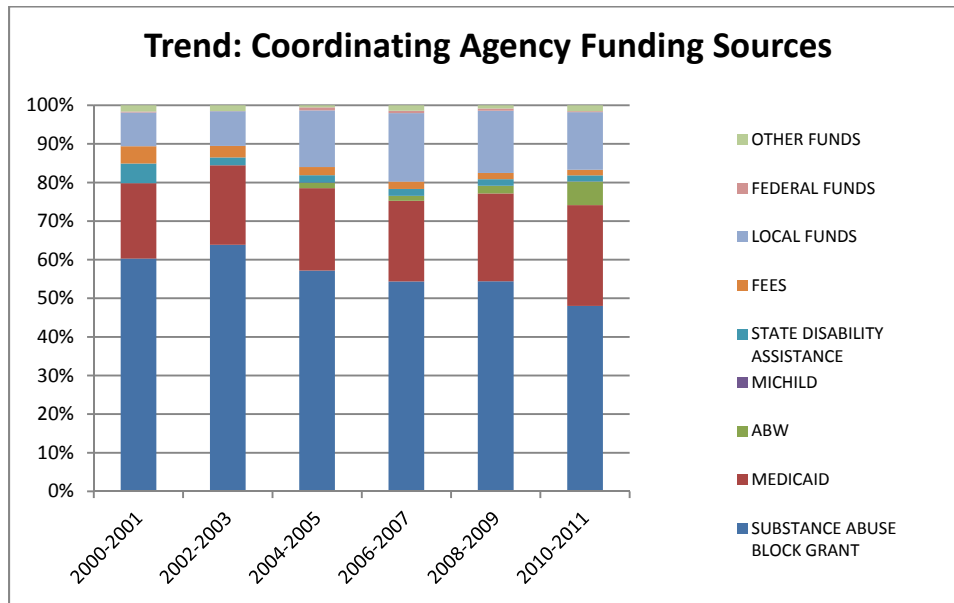
MICHIGAN ONLY

Certified Alcohol and Drug Counselor-M (**CADC-M**)
 Certified Prevention Consultant-M (**CPC-M**)
 Certified Prevention Specialist-M (**CPS-M**)
 Certified Clinical Supervisor-M (**CCS-M**)
 Assessment and Referral Management Specialist I and II (**ARMS-I and II**)

Attachment 8: Trend: Coordinating Agency Funding by Source 2000 – 2010

This chart shows the portion of annual CA funding from each source over a decade.

As a portion of all funding, federal Substance Abuse Block Grant funds and state General Funds for SUD, has decreased; funding from Medicaid and ABW have grown.



Attachment 9: Statewide SUD Services Expenditures and Revenues: 2000-01 - 2010-11

STATEWIDE SUD SERVICES EXPENDITURES AND REVENUES: 2000-01 - 2010-11										
FISCAL YEAR	SUBSTANCE ABUSE BLOCK	STATE DISABILITY				FEDERAL			TOTAL	
	GRANT	MEDICAID	ABW	MICHILD	ASSISTANCE	FEES	LOCAL FUNDS	FUNDS	OTHER FUNDS	TOTAL
2010-2011	\$67,222,577	\$36,601,150	\$8,477,785	\$69,533	\$2,238,997	\$1,998,948	\$20,906,002	\$364,135	\$2,115,066	\$139,994,193
2008-2009	\$78,136,364	\$32,679,304	\$2,833,385	\$58,393	\$2,400,725	\$2,362,163	\$23,143,067	\$836,113	\$1,174,376	\$143,623,890
2006-2007	\$74,403,550	\$28,628,385	\$1,703,913	\$43,796	\$2,422,647	\$2,633,464	\$24,281,199	\$853,079	\$1,915,843	\$136,885,876
2004-2005	\$74,830,230	\$27,929,205	\$1,793,730	\$92,640	\$2,483,665	\$2,763,968	\$19,224,462	\$1,018,056	\$691,235	\$130,827,191
2002-2003	\$78,677,580	\$25,396,688	\$0	\$0	\$2,505,427	\$3,674,787	\$11,057,552	\$49,601	\$1,837,581	\$123,199,216
2000-2001	\$75,092,770	\$24,313,407	\$0	\$0	\$6,317,294	\$5,579,786	\$10,916,954	\$281,776	\$2,006,342	\$124,508,329

	TOTAL FUNDS			BSAAS	MCAID		INTENSIVE		CASE	EARLY
	2010-2011	ADMIN 2010-11	AMS 2010-11	FUNDING	FUNDING	LOCAL FUNDING	OUTPATIENT	OUTPATIENT	MANAGEMENT	INTERVENTION
BABH/RIVERHAVEN	\$4,506,638	\$688,750	\$144,837	\$1,859,871	\$1,580,085	\$613,027	\$0	\$1,445,832	\$52,453	\$0
DETROIT DEPT. OF HEALTH	\$30,869,368	\$2,953,073	\$1,394,065	\$15,233,731	\$8,335,675	\$2,830,870	\$518,437	\$5,720,608	\$0	\$132
GENESEE COUNTY CMH	\$8,231,379	\$583,777	\$409,072	\$3,270,553	\$3,232,525	\$929,241	\$469,555	\$2,494,125	\$13,135	\$21,216
KALAMAZOO COUNTY CMH	\$7,970,612	\$722,334	\$696,742	\$4,128,528	\$1,436,938	\$1,601,269	\$0	\$2,998,718	\$87,393	\$0
LAKESHORE COORDINATING COUNCIL	\$7,213,028	\$570,654	\$341,706	\$3,671,756	\$1,413,137	\$1,363,274	\$538,655	\$2,178,078	\$4,922	\$0
MACOMB COUNTY CMH	\$7,354,425	\$968,455	\$329,232	\$3,516,923	\$2,270,395	\$905,820	\$145,194	\$1,692,123	\$298,378	\$0
MID-SOUTH SUBSTANCE ABUSE	\$11,523,448	\$1,105,571	\$284,606	\$5,211,618	\$2,988,967	\$1,748,158	\$0	\$4,153,565	\$959,126	0
NETWORK 180	\$9,201,583	\$881,848	\$710,132	\$3,245,049	\$3,262,123	\$2,045,606	\$0	\$2,090,211	\$911,849	0
NORTHERN MICHIGAN SUBSTANCE ABUSE	\$11,726,741	\$1,087,508	\$427,046	\$5,095,326	\$2,917,192	\$2,302,827	\$352,676	\$3,498,082	\$102,018	30218
OAKLAND COUNTY HEALTH DIVISION	\$8,574,318	\$775,641	\$688,810	\$4,134,697	\$2,108,105	\$1,379,284	\$452,824	\$2,173,143	\$18,858	0
PATHWAYS SUBSTANCE ABUSE	\$3,561,662	\$173,285	\$372,189	\$1,933,340	\$947,003	\$407,949	\$23,925	\$829,711	\$16,600	8033
SAGINAW COUNTY HEALTH DEPT	\$3,526,944	\$393,436	\$238,366	\$1,605,962	\$1,371,305	\$343,407	\$0	\$544,837	\$21,014	0
SOUTHEAST MICHIGAN COMM ALLIANCE	\$11,762,448	\$1,066,153	\$730,063	\$5,840,669	\$2,783,048	\$2,769,505	\$1,852,402	\$1,452,853	\$333,702	197124
ST. CLAIR COUNTY CMH	\$3,051,806	\$581,496	\$243,387	\$1,290,194	\$1,256,099	\$258,144	\$250,589	\$685,357	\$4,763	0
WASHTENAW COMM HEALTH ORGA	\$5,086,587	\$419,195	\$140,057	\$2,362,301	\$698,551	\$1,208,278	\$2,340	\$746,771	\$439,422	424011
WESTERN UP SUBSTANCE ABUSE	\$1,762,378	\$343,887	\$256,452	\$1,183,351	\$0	\$164,763	\$52,881	\$141,512	\$0	0
SALVATION ARMY HARBOR LIGHT	\$4,070,829	\$0	\$0	\$3,638,708	\$0	\$34,580	\$1,113,852	\$266,157	\$0	0
	\$139,994,194	\$13,315,063	\$7,406,762	\$67,222,577	\$36,601,148	\$20,906,002	\$5,773,330	\$33,111,683	\$3,263,633	\$680,734

	RECOVERY SUPPORT	METHADONE	DETOX	RESIDENTIAL	PREVENTION	OTHER	INTEGRATED	IOP CLIENTS	OP CLIENTS	DETOX CLIENTS	RESIDENTIAL CLIENTS
BABH/RIVERHAVEN	\$36,302	\$474,357	\$144,346	\$817,566	\$679,811	\$22,384	\$27,136	-	2,402	230	405
DETROIT DEPT. OF HEALTH	\$3,897,483	\$2,209,663	\$979,723	\$8,169,845	\$3,268,099	\$1,758,241	\$1,039,437	412	5,806	2,365	3,429
GENESEE COUNTY CMH	\$268,070	\$475,476	\$283,978	\$2,657,525	\$444,074	\$111,375	\$41,875	439	4,870	385	787
KALAMAZOO COUNTY CMH	\$148,286	\$536,118	\$356,305	\$727,307	\$1,274,166	\$423,243	\$250,904	-	4,866	471	898
LAKESHORE COORDINATING COUNCIL	\$20,154	\$239,902	\$316,160	\$1,228,471	\$1,532,923	\$241,403	\$49,712	456	3,099	296	1,094
MACOMB COUNTY CMH	\$51,014	\$556,620	\$497,208	\$1,864,286	\$904,780	\$47,135	\$588,526	234	3,896	925	956
MID-SOUTH SUBSTANCE ABUSE	\$4,020	\$976,273	\$871,016	\$1,734,300	\$1,388,613	\$46,358	\$2,363,909	-	3,713	680	756
NETWORK 180	\$521,378	\$904,727	\$239,752	\$1,605,877	\$955,035	\$380,775	\$1,943,240	-	2,460	222	383
NORTHERN MICHIGAN SUBSTANCE ABUSE	\$51,356	\$536,254	\$1,070,907	\$2,930,413	\$1,305,346	\$334,919	\$2,526,848	157	9,097	900	844
OAKLAND COUNTY HEALTH DIVISION	\$9,044	\$677,246	\$440,423	\$2,061,698	\$1,006,691	\$269,939	\$1,188,592	247	2,924	635	881
PATHWAYS SUBSTANCE ABUSE	\$91,507	\$0	\$75,635	\$1,013,715	\$786,907	\$170,156	\$94,057	23	1,190	71	535
SAGINAW COUNTY HEALTH DEPT	\$0	\$432,020	\$173,790	\$1,042,215	\$598,280	\$82,986	\$165	-	781	235	300
SOUTHEAST MICHIGAN COMM ALLIANCE	\$189,011	\$135,450	\$679,167	\$2,902,212	\$1,632,774	\$591,535	\$2,628,395	1,291	2,237	1,380	1,274
ST. CLAIR COUNTY CMH	\$0	\$66,548	\$194,450	\$714,222	\$260,426	\$50,568	\$77,192	194	1,515	217	305
WASHTENAW COMM HEALTH ORGA	\$338,271	\$92,493	\$517,748	\$522,895	\$910,124	\$533,260	\$1,248,593	8	654	285	135
WESTERN UP SUBSTANCE ABUSE	\$0	\$11,073	\$10,305	\$368,662	\$308,178	\$269,428	\$0	20	225	2	200
SALVATION ARMY HARBOR LIGHT	\$0	\$0	\$800,781	\$1,890,039	\$0	\$0	\$0	110	155	1,505	347
	\$5,625,896	\$8,324,220	\$7,651,694	\$32,251,248	\$17,256,227	\$5,333,705	\$14,068,581	3,591	49,890	10,804	13,529

Attachment 10: Funding Flow: Public Treatment System for SUD

This diagram shows how funds flow to coordinating agencies and how coordinating agencies channel funds to clients.

